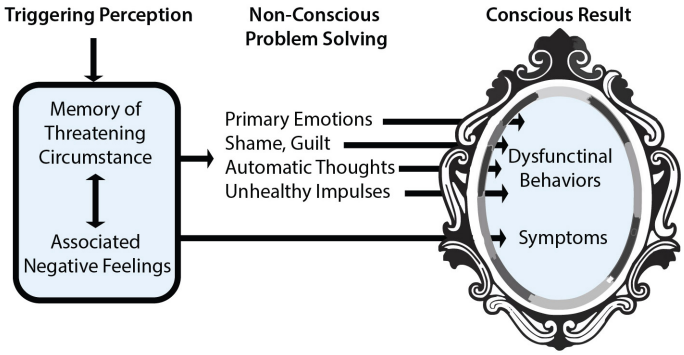
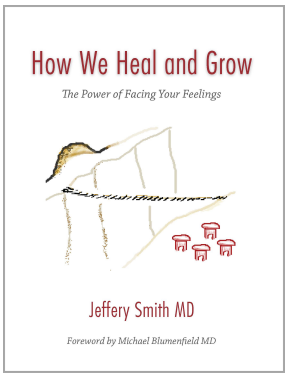
Getting the Most From Your Therapy



Become an Educated Consumer

Jeffery Smith MD

Also by Dr. Smith



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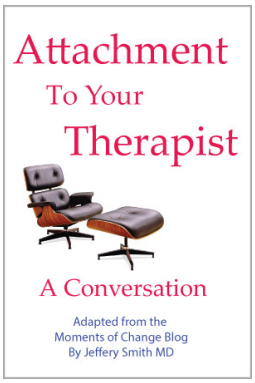

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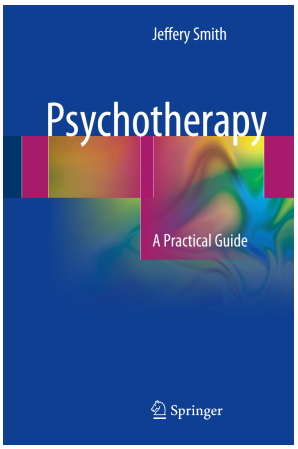

Paul Wachtel, PhD, CUNY Distinguished Professor

It is remarkable how much Jeffery Smith packs into a small, readable volume. Covering a wide range of theoretical perspectives and clinical challenges, Smith lays out clearly and in detail how he works and offers a valuable integrative understanding of the essential elements in good clinical work. An important contribution to the field.

John C Norcross, PhD, ABPP, Distinguished Professor, University of Scranton & SUNY Upstate Medical University

A thoughtful, integrative guide to psychotherapy from a wise and seasoned psychiatrist. Dr. Smith demonstrates charity to all therapies that work and malice only toward the rigid and ineffective. His emphasis on entrenched dysfunctional patterns and affect avoidance will prove useful to practitioners of all professions and persuasions.
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Getting the Most From Your Therapy

Become an Educated Consumer

Jeffery Smith MD

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To Anne

Contents

Introduction

Congratulations, you want to upgrade yourself. Or maybe you are just thinking about trading in those patterns that rob you of energy and satisfaction. You might want to leave that old musty cave and move to a better, friendlier happier world on the other side of the bridge. This book is aimed at helping you and your therapist make a great start and benefit the most from your sessions together. If you are not sure that therapy is for you, the information offered here will help you answer that question by looking closely at how we come to have problems and what to do about them.

Some years ago my daughter, Anne, suggested that I write on how to tell if your therapy is working up to its potential. There are some principles that apply to every therapy (Chapter 4), but as I thought about writing on the topic, it became clear that to make the most difference, I would have to help you, the reader, understand more about your own personal journey of healing and growth. In short, I would have to help you become an educated consumer.

One the first things that may come up in your search for a therapist if you don't already have one is–what school? Cognitive behavioral, Psychoanalysis, Emotion Focused Therapy? If you have a therapist already he or she may be adhering to techniques from a particular school. The

education proposed here will take advantage of recent advances in the integration of different therapies and new science to help you understand why we humans so often carry the extra weight of unfinished business from long ago, how we can resolve these issues and how to step into more positive ways of living.

My passion and interest for most of my professional career as a therapist and teacher has been understanding just how people change. To myself and many colleagues, it is increasingly clear that now is the time to break out of the limitations of monolithic schools and focus on universal principles of change that apply to all therapies. New discoveries about how old triggers of dysfunction can actually be erased give us a glimpse into how talk exchanged with your therapist can reach deep into your brain, activate the few nerve cells where trouble is being held, and modify their synapses to give you relief.

In the first chapters we will examine how and why we have problems, and how psychotherapy can help. Chapter 4 will describe eight things you can do that will enhance any therapy. The next three chapters will go into detail about specific types of problems, how to recognize them, and how to work with your therapist on your individual challenges. Chapter eight will introduce how thinking of yourself as having an inner child can give your therapy a much warmer and more accepting tone, all the while, making it even more effective. In Chapter 9, I will give you a peek behind the curtain to see how things look from the point of view of your therapist. Finally, in the Appendix, you will find the Scarsdale Psychotherapy Self-Examination (SPSE), a tool for evaluating the different aspects of your therapy and People and Resources, an annotated list of people in the field who have important things to say about therapy, healing, and growth.

A few notes: While this book covers the great majority of problems found in everyday clinical practice, there are a few limitations. I have not

addressed specific medication treatments, since you will need to work with a prescriber on those. In addition, I have focused on the individual and left out consideration of group and family dynamics. This isn't because I don't think they are important, but to keep the sharpest possible focus on individual change processes. Finally, some more severe forms of mental illness may be helped with psychotherapy, but I felt that delving into the details of very early development and related problems was too far from what would be relevant to the great majority of readers.

Resources: Throughout the text I mention important figures who have influenced my thinking. They are listed in the Appendix under People and Resources. To learn more about these leaders and their work, I encourage you to search the Internet for more on the ideas and techniques they have promoted and the publications they have authored.

Disclaimer: The ideas presented here are solely to stimulate thinking between the reader and his or her therapist. These ideas do not apply to all situations and may not apply in individual cases. For that reason, this book should not be taken as a substitute for any part of the work of a credentialed, licensed therapist or other mental health professional.

One

The Big Questions

Do I need therapy? Can therapy really help? Is my problem 'serious' enough to warrant therapy? Is it so bad that I'll never get better? Is therapy the right answer? Which therapy is right for me? Can therapy harm me as well as help me? How can I find a good therapist?

These are the kinds of questions that can come up whether you're in therapy or just thinking about it. They are all good questions, and ones you should ask. As with any other service today, an educated consumer is the best consumer.

The short answer to the question 'Do I need therapy' starts with asking yourself a question. Do you find yourself facing certain problems over and over in your life and, no matter what you do, nothing seems to change? Some examples–you can't find a satisfying romantic partnership. Every time you find a job you have problems with your boss and get fired or need to quit. Somehow, money just seems to fly out of your bank account and you end up having to start your savings all over again. You just feel generally dissatisfied too much of the time.

If your answer is somewhere in the realm of "Yes," then consider this an invitation to learn more about how human it is to have troublesome

patterns, that they are not so hard to understand and that the more you know, the better equipped you will be to unravel yours.

Is Therapy Warranted?

If you have dysfunctional patterns that detract from your satisfaction and success in life, then the question is really whether the possible results are worth your investment. What I see in my practice is that seeking out a referral and picking up the phone is far from easy. Rarely do people go to that trouble unless their suffering is painful enough to warrant a serious investment of time, money, and effort.

What happens much more often is that people give themselves reasons why *not* to seek therapy. They tell themselves that their problems are trivial, or that they are beyond help, or that no one could be trusted to do the job. In Chapter 2, we will discuss, at length, how the mind works to discourage change, how it is capable of sending negative thoughts into consciousness that serve to protect us from anything that promises to be difficult. Therapy can stir things up, so our automatic thoughts may be crafted to convince us to stay with the status quo. That is a shame.

It is true that change can bring up uncomfortable feelings but, from years of practice, I have seen that even the most terrible feelings can heal when they are experienced in a context of safety and empathic connection. My bias is strongly in the direction that the truth is always better in the long run than comforting illusions. Furthermore, the dread we have of meeting our difficult feelings comes from the time when those feelings were originally buried. Today we have resources that were not available at the time and circumstances may have changed. For that reason, I generally reassure my patients that the worries they have about what may be uncovered in therapy are not realistic. Instead, at the end of the process, they will find healing and relief.

You will also read here about a sometimes-neglected part of the therapy process: growth and maturation. One of the ways we protect ourselves from damage due to adverse circumstances is by leaving a young part of the self behind. For example, children who have to grow up too soon always leave a part of themselves behind, waiting until whatever support or love was missing at the time appears and allows them to continue growing. In Chapter 8, "Befriending the Child Within," I explain how therapy goes beyond ridding yourself of dysfunctional patterns. There is richness in the experience of taking our young self by the hand with kindness and compassion and helping her or him go through the normal and healthy (but scary) processes of growth and development. In this way, therapy often gives as much and more than it takes away.

In the end, it will have to be your decision to invest in psychotherapy. What I can say is that this amazing process can work remarkably well to free us from the worst constraints of our problem patterns.

Can I be helped?

This is a question to ask your therapist. The vast majority of patients can be helped. My thought is that you should expect substantial improvement in any dysfunctional pattern. Some are harder to change than others. Patterns that are deeply ingrained may benefit from continuing work after formal therapy ends. Among the most challenging problems are the ones related to very early development. "Schemas," described in Chapter 5 are early, non-verbal patterns that are triggered quite automatically and may, therefore, be harder to change. Even so, like all the others, there are ways to address these problems as well.

Is Psychotherapy the Right Answer?

If you can identify one or more emotional problems in your life, then I think psychotherapy is the first approach to consider. As I will show in these pages, therapy is a way of reaching deep into the mind to modify just those synapses that need to change. In that way, it is precise, focused, and minimally invasive.

What about coaching? Could that do the job? The answer is sometimes. When simply changing a dysfunctional behavior pattern is feasible and not too much difficult emotion gets stirred up in the process, then coaching is a great idea. Coaching is not sufficient for problems that are deeply entrenched and resistant to change. In those cases, the dysfunctional pattern is usually covering up substantial and difficult emotions. Once the mind's protection is removed then once-dreaded feelings tend to come to the surface, where an experienced therapist may be needed to help with healing.

"But on TV, I see medications that can put a beautiful smile on just about anyone." Well, those smiles are worn by actors. As an MD psychiatrist, thinking of the balance between benefits and side effects, I tend to be skeptical. Let me give you some of the reasons for my concern that medications are not always the easiest or best solution.

First, psychiatric medications enter the fluid bathing the brain and exert their effects on millions of nerve cells. Pharmacologists try to find drugs that will have a greater effect on the few cells that are the source of trouble, but this is hard to achieve. Side-effects pose a knotty problem because there is no way to keep the drug from having effects on cells that have nothing to do with our problem, but serve some other purpose.

Second, we assume that we are fixing a "chemical imbalance." Unfortunately, we are trying to rebalance one of the most extensively self-regulating systems in the universe. Often this is like trying to change the water level in your toilet tank by pouring in more water. The toilet is a

self-regulating system that resists any attempt to "rebalance" it. So it isn't surprising to me that many medication treatments work well at first, but in the long run don't make as much difference as we might hope.

Third, you will read in these pages that emotions are accessible to healing only when they are actually *felt*. Medications that suppress emotions also stop the emotional healing that is central to psychotherapy. This is most true of benzodiazepine sedatives that suppress anxiety, but there is some new evidence that serotonin-enhancing antidepressants have a similar effect.

Finally, using medications sends a message to a mind that hates hard work: "Relax, I'll do the heavy lifting." The mind tends to credit the medication with the results and to reduce investment in the work of therapy, especially facing difficult feelings.

Can self-help fulfill my needs? I have had very good experiences with people who were simultaneously involved in self-help, especially 12-step programs. I think of these as really good at what they do best– achieving and maintaining abstinence. For psychological problems, self-help groups go in the right direction but may not be powerful enough to overcome our mind's ability to hold onto the status quo. I think an effective, trained therapist may be better able to help us steer around our blind spots.

What about Mindfulness Meditation? Mindfulness is a good way of gaining perspective on painful feelings. To my thinking, it works in basically the same way as sharing feelings with a friend or therapist. This is because meditation really isn't done in a state of solitude. It puts us in a state of connection with some presence greater than ourselves and gives us a larger perspective on our small selves in the greater universe. This broadening of perspective is much like what happens when we share our feelings with an empathic witness, which is the core of healing. What meditation can't do is to untangle the web of avoidance mechanisms that keep us away from the feelings that need to heal.

Which Psychotherapy?

One of the important themes of this book is that it is time to stop thinking of different therapies, and time to think of the specific units of work to be done and the therapeutic tools that might best help. This has been called a "modular" approach. Furthermore, research has shown that the "brand" of therapy has little effect on the outcome. John Norcross (See People and Resources in the Appendix) has shown that the relationship you have with your therapist is far more important than the particular technique. Since the great majority of therapies all seek to help with the same range of problems, it makes sense to think that they simply represent variations on how to accomplish similar tasks.

While the particular school makes little difference, again it is Dr. Norcross, in his book, *Psychotherapy Relationships that Work* (2002), who shows that being on the same page with regard to goals and approach greatly improves the chances of success. A therapist who is positive about you, validates your feelings, and is supportive has also been shown to be very helpful.

As we go forward, I will show you how to make progress without worrying about which therapy. Instead, we will focus on what tasks need to be accomplished and how best to get results.

Are There Risks?

The most common risk is that nothing happens. My impression is that too often, therapists have understood how therapy looks, that is, what to say and do, but not how it works–how the words and actions will change something in their patient. Without a sense of how to produce change the result is likely to be no significant improvement of your problems.

Alongside failure to bring about change, the next greatest risk is a therapist who is not equipped to deal with strong feelings or challenging

reenactments. Intensive therapy can be stressful for any therapist. When the relationship becomes intense, the therapist needs to be particularly at peace with him or herself. This usually requires having had serious personal therapy. I created the Scarsdale Psychotherapy Self-Examination (SPSE), an 18 item questionnaire reprinted in the Appendix as a tool for evaluating different aspects of your therapy. Failure to maintain boundaries, judgmental and rejecting responses are some of the more obvious indicators that a therapist may not be up to the demands of the job. If you have questions, the best thing is to raise them early, questioning the therapist and seeking advice or consultation with other professionals or people you trust. One commenter on my blog mentioned being in therapy for eight years and finally telling the therapist about strong feelings regarding the relationship. The therapist became upset and terminated the therapy. This disaster should have happened eight years earlier.

Occasionally, anticipated change can be perceived by the mind as posing a dangerous enough threat to unleash seriously overwhelming feelings. Even if the perception of danger dates from long ago and is not realistic today, the mind's reaction to a perceived threat can be drastic. This is where good professional help and careful pacing may be critical. The fear of change can be so great that, in itself, it can cause a breakdown of functioning. One example is work with people prone to psychosis. If unraveling of the personality is a possible response to stress, the risk should be weighed carefully with your therapist.

Since therapy does involve stress, people with addictions may naturally resort to their addiction to manage stress. This tendency will need to be addressed before taking on difficult issues in therapy.

Harsh therapy can cause re-traumatization, or even trauma for the first time. What it generally can't do is create pathology where there was none. This issue has been brought up in relation to dissociative identity disorder or multiple personality. Extensive research has shown that even over-enthusiastic therapists cannot create alternative personalities.

One way to control the risk is to have a way to monitor progress. For this, therapy should have a clear rationale and make sense. Having a well-defined goal gives you a way of following progress and holding yourself and your therapist accountable. Any questions should be raised as soon as they are formulated and should be answered to your satisfaction. Above all, the relationship should feel safe and conducive to trying new behaviors. With these safety factors, the risks of therapy are minimized.

Finding a Good Therapist

This is really a hard question because it is not easy to tell from the outside. Get recommendations. Watch for early red flags, and don't override your concerns. Ask yourself if you feel the person "gets you." Be sure your therapist is properly credentialed. Take the SPSS in the Appendix.

The variable quality of therapists is a challenging public health issue. I wish there were a better way to find whom to trust. I have seen too many therapies that did not work out well. That is why I want you to be an educated consumer and to actively monitor your progress.

What Therapy Does

So you are interested in entering therapy and in being an educated consumer. I want to start with a concept that will be carried throughout this book. Psychotherapy helps us let go of and replace "Entrenched Dysfunctional Patterns," EDPs for short. Let's break the term down into its parts. If they weren't *entrenched*, then you would already have solved your problems and would have no reason to think about therapy. *Dysfunctional* means that in some way, they rob you of success and satisfaction that could be part of your life. And, finally, *Pattern* means

that they are recognizable and repetitive enough to be the targets of your efforts at change.

EDPs encompass all the troublesome problems that can be helped by psychotherapy. They all start out as solutions to problems in life. Eventually they become problems in themselves. Our mind wants to keep them because, somewhere inside, there is a belief that they are still preventing us from experiencing really painful feelings. Therapy is a collection of ways, gathered over many years by thousands of smart people, to help you trade your EDPs for healthier ways of functioning and to prove to your inner self that nothing bad has come of it.

While EDPs are often arranged in layers, only one, the one at the surface, is the most accessible to the work of therapy. So, for the most part, we can reduce therapy to recognizing that most accessible layer and finding how to give yourself something better. In the chapters that follow, you will find the full gamut of EDPs described and explained, along with suggestions about what you can do in general and, specifically for each kind of EDP, how to have success in your journey.

You will most likely develop hypotheses about which kinds of EDPs plague you, but self-diagnosis is always perilous. You should take what is said here as ideas and work with a properly credentialed therapist to build a sense of your own EDPs, how they fit together and which one is next in line, ready for you to set about the work of change.

Two

Time for Change

If you have researched on the Internet or if you have looked lately at the self-help section of the bookstore, you have probably noticed a bewildering number of new and revolutionary therapies. A few years ago, it was all about Cognitive Behavioral Therapy, and before that, traditional talk therapy, but suddenly today there are a host of new ideas. Ferment is in the air. What should you learn about? Is it Schema therapy, Dialectical Behavior Therapy, Mindfulness, or Acceptance and Commitment? All are built on great ideas. How can we find our way in this confusing jungle?

The problem is that the field of psychotherapy, with only a little exaggeration, is still organized like the schools of the Middle Ages. Each brand of therapy has its origin in remarkable insights by a great innovator. Disciples treat the founder's writings like sacred scripture, emphasizing faithfulness to the pure model and how it is different from all others. Those who deviate are shunned unless they start a school of their own with their own disciples.

At least half of all practicing therapists actually use more than one technique. The Society for the Exploration of Psychotherapy Integration, SEPI, has been active for over three decades promoting a less parochial

view, but most of what is written and taught is still focused on isolated schools of treatment.

A Solution

Fortunately we don't have to give up the large amount of accumulated wisdom embodied in traditional schools or start from "scratch." What is offered here is a big tent under which the many therapies can coexist.

In this chapter, I will make a case for a "modular" approach to your treatment in which we identify the task at hand and choose the tools that are best suited to that job with relatively little concern about who may have invented them. The details of the argument are more for your interest than essential for you to become an educated consumer. In case you go lightly over the technicalities, let me give you the high points of the next few pages:

1. **Opportunity:** While many therapies hold tightly to their incompatible theories, the area that has been the least understood by all is how therapy actually brings about change. This has created a vacuum where new science can fill in the unknown with observations that give a common ground to all.
2. **A Model for Change:** Understanding neurophysiologically the two pathways by which the painful emotions of trauma can heal gives us a way of understanding how psychotherapy works by changing information held in the brain.
3. **Activation:** Both kinds of healing require "activation" of feelings and other mental contents so that they enter consciousness. Words spoken in session accomplish this by awakening feelings, memories and knowledge.
4. **A Safe Relationship:** Healing also requires that conditions in the session be in contrast to the conditions that caused the

trouble. A safe therapeutic relationship provides these conditions.

5. **Behavior Change:** Letting go of patterns of avoidance that cause feelings to be distanced and deactivated is also needed so you can feel your feelings and allow them to heal.

What all this adds up to is that all therapies do two things: they help bring your feelings "into the room" so they can heal, and they help you let go of whatever avoidance mechanisms your mind utilizes to keep your feelings far away. The main tool that makes both goals achievable is the relationship you have with your therapist. The therapist is the one who challenges, motivates and encourages you to be vulnerable and when feelings come up, helps you to feel safe and supported so that your painful feelings can heal.

It is OK to go quickly through the sections that follow, though I hope you will find the scientific material interesting. Then let's get down to business again at the heading *The Basic Unit of Change*, in this chapter. From then on we will focus directly on what you need to know to understand your EDPs and how to trade them in.

Now, I'll give you a foundation for understanding how therapy really works and how all therapies really do the same things.

The Mystery of Therapeutic Action

Surprisingly, the greatest mystery about psychotherapy has been how it actually works to bring about change. Without knowing exactly how therapy works, designing the best approach to an individual problem has necessarily been based on intuition and experience.

Many possible explanations of how therapy works have been debated. Some have focused on the personal interaction. The "corrective emotional experience," since Carl Rogers coined the term, has generated

a great deal of discussion but little agreement. While many have acknowledged the importance of the therapeutic relationship, there has been little consensus about just how that might work. Other theories have emphasized ideas over relationship. Cognitive Behavioral Therapy (CBT) prefers to consider the therapist as a kindly technician who helps correct erroneous ideas. More recently, mindfulness has been proposed as the universal curative element in psychotherapy. If this feels like the proverb of blind men examining an elephant, you are not wrong.

How, then, can psychotherapy be successful without an understanding of how it works? Just as in tribal medicine, intuition has led to successful interventions, which, in turn, have led each school to build a body of experience. Experience is then codified into a set of rules and procedures. New therapists are taught to apply the rules and follow procedures in the expectation that the patient (you) will sooner or later get better. Once again, as in tribal medicine, schools have created metaphors to describe and explain what is happening. Therapists are taught to "correct irrational cognitions" or to "resolve inner conflicts." These explanations help make sense of therapy and have allowed each school to refine its procedures, but they are mostly incompatible with one another and are limited when it comes to tracing a complete path from words spoken to changes in the brain.

Cracking the Code

Two important advances have opened the way to identifying how talk therapy can produce changes in nerve cells so as to relieve distress. The first, is understanding how information is stored in the brain. Only in recent decades have neuroscientists like Eric Kandel identified, with some certainty, where and how memories and knowledge of the world are stored.

Neural networks are groups of nerve cells in the brain that have a tendency to fire as a unit. These groupings of cells, when they fire together, represent chunks of information. What makes them form a unit is heightened sensitivity in the synapses that link them together. So, in the end, information is expressed in the adjustment of specific sets of synapses. The activation of one of these networks of nerve cells is synonymous with the brain recognizing or retrieving a piece of information.

Understanding how memory is stored is hugely important because the Entrenched Dysfunctional Patterns (EDPs) that make us seek therapy start with recognition of a problematic situation or condition in life. The perceptions that trigger an EDP remind us of a previously formed memory or idea, which has been associated with danger or pain. Maybe long ago that recognition and our reaction to it was actually a helpful one but now, it gets us into trouble. Knowing that every dysfunctional pattern starts with activation of a group of nerve cells gives us a clear starting point for understanding our problems and how they can be resolved. Once the neural network is activated, what happens next? That particular memory is associated with a negative emotion. The emotion then energizes a self-protective reaction. When the reaction is inappropriate or unhealthy, we recognize it as pathology or dysfunction.

What, then, if we were able to break the link between the memory of a triggering situation and the negative emotion that leads to a dysfunctional reaction? Then the EDP would not take place. This is one of the two main actions of psychotherapy. When I refer to “healing” a painful feeling, what really happens is just that, breaking of a link. The perceived circumstance ceases to set off a visceral emotional reaction.

The second major finding of neuroscience comes from the field of trauma, where recent discoveries have shed light on two basic ways people can be relieved of the distress that goes with recalling their painful

experience. For your interest, I'll give a technical explanation but skimming over it won't do you any harm.

In rats, humans and many other species, learned fear reactions happen when the brain recognizes a set of circumstances which lead to flight or fight. This recognition takes place in a brain structure called the amygdala, a center for recognizing danger (or opportunity) and triggering the appropriate reaction. This alarm system continues to react, even though the response may no longer be appropriate, as when a soldier hears the crack of a celebratory firecracker. This system operates outside of consciousness and does its work more rapidly than the time it takes for our thinking brain to figure out what happened. Have you ever had a close call and noticed the hair on your arm standing up before you were able to find the words to describe what caused it?

Anxiety, especially when it is inappropriate, is a very big problem for humans. For this reason, neuroscientists have been particularly interested in the details of how it works. They have been even more interested in how we might *unlearn* an association between a remembered circumstance and a distressing emotion. How can such unlearning take place? Recent work has characterized two ways by which the link between recognition of a condition and triggering of a flight or fight reaction can be blocked or unlearned. Both have been studied in detail, down to their very distinct biochemical signatures.

Extinction

The first healing mechanism to be elucidated is called *extinction*. It was initially described by Pavlov as the gradual elimination of a learned reaction when the triggering reward or punishment is no longer present. On a neurobiological level, it turns out that the recognition component is not actually unlearned; nor is the link to a negative emotion. Instead, the emotional reaction, itself, is inhibited. The memory of the original cir-

cumstance has been shown to be essentially permanent. The neural network representing the memory continues to be activated whenever life provides a reminder. What is extinguished is the reaction to the alarm signal. The protective reaction is stopped before it can be felt. This blocking is the result of inhibitory signals sent from the cortex, the thinking part of the brain located in the frontal area. In extinction, the brain is able to re-assess the situation as non-dangerous and send inhibitory signals to tell the alarm center that a flight-fight reaction will not be necessary.

This inhibition requires two conditions in order to become established. First, the neural networks representing the "dangerous" condition must be activated. If they are quiet, then inhibition of the reaction cannot be learned.

In therapy, this means that you must actually experience the scary feelings for the reaction to be modified by extinction. This fact is important because we all have such a strong tendency to find ways to distance uncomfortable emotions. In the early days of behavior therapy "desensitization treatment" taught the anxious person to relax and suppress anxiety. This treatment was found to lack effectiveness precisely because the network representing feelings of alarm was distanced and deactivated. Without activation, inhibition couldn't be learned. "Exposure therapy" was the answer. This treatment introduced ways to enhance activation of uncomfortable memories and has been shown to be much more effective.

The second necessary condition for extinction is that the thinking brain must perceive that the current situation is really not dangerous. In other words, the expectation of danger generated in the amygdala must be "disconfirmed."

Exposure therapy for trauma reminds the patient of the traumatic situation, for example, by showing video of war scenes. This activates the memory and the associated fear, but takes place in a context where it is

clear there is no longer any danger. With repeated pairing of the feeling of fear with awareness of safety, the fear reaction is gradually suppressed. This treatment is one of two approved by the Veterans Administration for treatment of war trauma. The only problem with the treatment is that it is not permanent. Repeated practice is needed to establish and maintain awareness that what looks dangerous is really not.

Reconsolidation

Even more exciting, in 2004, a group of researchers led by Sevil Duvarci and Karim Nader demonstrated a new way to stop fear reactions. Fear reactions can be *erased*. Amazingly, the erasure is permanent and does not require ongoing work to maintain it. What happens is that the synapses that carry the association between a recognized "dangerous" condition and the fear that causes distress, can be erased. The end result is that fear is no longer associated with the remembered condition. What once was once recognized as danger is now treated as no more threatening than a sunny day.

How can we make this erasure happen? Once again the fear reaction must be activated. Just as in extinction, one must actually be experiencing the scary emotions. When this activation is quite intense, then a window in time opens up starting about 10 minutes after the activation and lasting till about 3 hours later. During this time a process called *reconsolidation* allows learned information to change. The recall (activation) of memories temporarily makes their connections (synapses) volatile and subject to new learning, but only during that three-hour time period.

The term "reconsolidation" originally referred to the more usual situation for animals where the memory is activated and then "reconsolidated," strengthening the original fearful association. When a deer has a second close call with a car, the memory of danger is recon-

firmed and enhanced by reconsolidation, so that the next time, the deer will be even more frightened and stay even farther away.

But what happens if the memory of an old fear is activated in the context of a safe place and a safe relationship? Then the memory is reconsolidated (Maybe "deconsolidated" would be a better term) into a new configuration where the original condition is no longer associated with fear or danger. Detailed biochemical experiments have proven that his mechanism of erasure is quite different and distinct from extinction.

There is still some controversy about whether reconsolidation actually operates in the treatment of human trauma survivors. In animal experiments, the older a fear memory, the more strongly it has to be activated for reconsolidation to work. Doubt has been expressed that human trauma from years before can be subject to reconsolidation. Bruce Ecker is a champion of the point of view that reconsolidation is a major part of the healing in psychotherapy and my experience echoes his findings.

Here is why I agree with Ecker that reconsolidation actually does work in therapy. Of the two known healing mechanisms, reconsolidation is the only one that is permanent and effortless. Extinction, in contrast, is subject to relapse and requires ongoing reinforcement. Therefore, any clear example of transformation of fear memories that is permanent and effortless could only be the result of reconsolidation.

In fact, there have been many accounts over the past 120 years, of permanent, effortless recovery from painful reactions related to trauma. In fact, this change process was what led to the invention of the "talking cure." One of the first cases described was that of Anna O, treated by Joseph Breuer, Freud's mentor and associate. Anna, herself, invented talk therapy in which she recalled and described to Breuer her traumatic experiences. As she performed what she called "chimney sweeping" severe symptoms such as paralysis (then called hysteria, now conversion), melted away and did not return.

Her treatment was marred by the then-unknown phenomenon of transference in her relationship with Dr. Breuer, but the permanent and effortless resolution of her symptoms was reported by Breuer and Freud in a paper published in 1893. They called the phenomenon *catharsis*, probably because of the strong and emotional activation of her memories followed by remarkable relief. My own, repeated experiences with similar permanent and effortless resolution (that is, after the very hard work of gaining access to the feelings) of symptoms, was what led to a career-long interest in how therapy works.

Emotional Healing

These new insights into the exact mechanisms involved in resolution of fear memories make it possible to trace the full chain of events involved in this form of psychotherapy. Words spoken in session to describe a scary experience activate fear memories. Next, the safe context of the therapy and the relationship provide disconfirmation of the danger, which allows for adjustment of synapses. In extinction, the cerebral cortex learns to inhibit the nerve cells involved in generating a fear reaction. In reconsolidation, the link between the memory and the associated negative emotion is erased. In both cases, the fear memory no longer triggers painful affects.

The healing of trauma gives us a powerful model for how words can lead to resolution of EDPs. I will show, in the chapters that follow, that changing information in the brain by adjustment of synapses is the basis of most therapeutic action. In Chapter 5 you will encounter "hidden agendas," which have, at their core, things we have learned about how life and relationships work. Bruce Ecker believes that changing these ideas, since they are stored in a form similar to memories, involves reconsolidation as well. In Chapter 6, the discussion of the conscience and values will show that, like the memory of a fear inducing experience,

values, themselves, seem to be permanent. However, in a manner similar to detoxification of fear memories by breaking their association with fear, unhealthy values are, in effect, modified by changing the way they are applied. Yet another healing process is grieving. Here, the letting go seems to take it's own time. Whether this is because we let go of a small chunk of the overall loss with each wave of feeling or for some other reason is not clear. In all of these instances, what is happening on a neuronal level is still changing stored information by adjusting synapses.

What about the role of new growth and development in replacing dysfunctional patterns? Antonio Pascual-Leone points out that filling in deficits in maturation as well as inventing novel solutions to problems are "categorically new" products of the mind that represent an equally important therapeutic pathway. Growing does not involve undoing associations; rather, it happens when we create new ones. All of these modes of healing and growth involve adjustments in synapses that require activation. It is the combination of talk, which activates neurons, and the safe relationship created with your therapist that makes change possible.

EDPs

As described above, the phrase "Entrenched Dysfunctional Patterns," makes a useful basket to hold all the problems that make us seek psychotherapy. Expanding slightly on the original description, *Entrenched* means that we are stuck in them. If this were not the case, then our own efforts, with the help of family and friends, would long since have resolved these problems. There would be no need to seek professional help. *Dysfunctional* means that the patterns take us away from what we consider to be best for ourselves. Unless we are personally convinced that our patterns are dysfunctional, then we will not be likely to seek therapy. Finally*, Pattern* implies some combination of feelings,

thoughts, behaviors and values that are clearly identifiable so we can imagine the possibility of trading them in for better ones.

What makes the concept of EDPs so useful is that, as we will see, they all come from a single source, the mind's drive to get away from problematic feelings. Not only do they have one origin, but the main pathway to their resolution is facing just those feelings that once caused our dread. It is this simplicity of causation and cure that makes it possible to build the big tent that can hold so many schools of therapy.

What About Biology?

There is a complication, the role of biology. Some psychological problems are partially or wholly caused by biology or genetics, and may not be accessible to psychotherapy. In America, there has been an unfortunate over-emphasis on the chemistry and biology of psychological problems and on drug treatment. In my experience, the majority of problems people bring to my office are psychological in origin. Nonetheless, not all problems are best approached through psychotherapy alone, and some, like our inborn temperament, may hardly be subject to change at all.

How can you tell the difference? My best advice in this murky area is, working with a qualified professional, to consider first if a dysfunctional pattern can best be explained as primarily psychological. If so, then approaching it through psychotherapy is likely to make sense. If not, a biological approach may be needed. As therapy unfolds, I have emphasized the need to monitor progress. If you, or your therapist, have concerns about the rate of progress, then it is time to consider other explanations and to consider whether biological factors might have been missed or not addressed adequately. Not infrequently, even problems that have a strong biological component may still have aspects that can be identified as Entrenched Dysfunctional Patterns and addressed

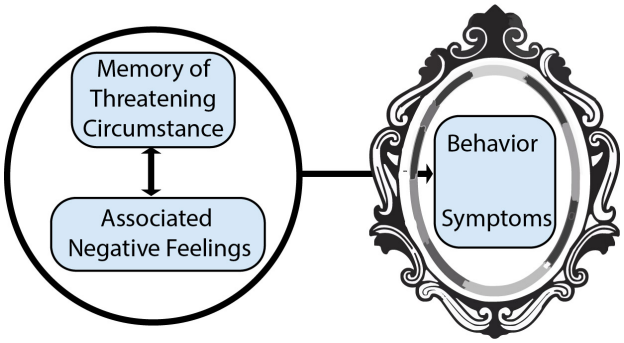
through psychotherapy. A good example is depression, which may have a strong biological component, but usually involves EDPs as well.

Biology is not only a matter of genetics and disease. Epigenetics is the new, but exploding field of how genes are turned on and off by experience. The role these play in therapy may be additive and supportive of changes in information. As with all biological factors, it is hard to tell the difference between improvements in functioning due to changes in gene expression and those due to changes in information. The changes we can track most clearly and precisely in therapy are the ones discussed here, involving the mind and its contents.

So, in the discussion that follows, I will exclude those biological aspects that have to do with our chemical environment and concentrate, instead, on the powerful changes in information that you and your therapist will utilize to replace your EDPs with healthy patterns.

The Basic Unit of Change

Not only does the concept of Entrenched Dysfunctional Patterns link the origin of psychological problems with their cure, but EDPs have a common structure as well. It is captured in this diagram:



Memory + Emotion + Conscious Behavior or Symptom

All EDPs are reactions to some perceived circumstance or condition. The perception activates the first component, a memory trace in the brain. This memory trace carries an association with a negative emotion that gives it a threatening quality. Together, they trigger a conscious reaction consisting of the urge to perform a dysfunctional behavior or the involuntary appearance of a symptom.

There are two ways to resolve an EDP. One is to break the link between the memory and the distressing emotion, as in extinction and reconsolidation, and the second is, by conscious effort, to eliminate a dysfunctional behavior. Let's think of these as the emotional approach and the behavioral one. By behavioral, I mean anything that we can change by conscious effort, which may include irrational thoughts, behaviors and values. This is where growth and development, that is, the creation of new ideas and behavior patterns, can be part of replacing old, unhealthy ones. Involuntary symptoms like depression and anxiety can't be controlled directly but can be approached by working with thoughts and behaviors that sustain and amplify those symptoms.

In actual practice, every person's problems are unique and individual, but consist of layers of EDPs, starting with an original one, aimed at avoiding some painful, overwhelming or uncomfortable feeling. On top of that, more layers of protection are often formed to keep the individual as far as possible from the troublesome feeling. In therapy, we usually start with the one that is most accessible and work our way down to the original layer. Recalling that each EDP can be approached from either of two directions, the emotional one or the behavioral one, what makes the most sense is to start with the EDP closest to the surface and use whichever point of entry is easier, or with both at once.

If you look at the self-help section in your bookstore, you will see that the therapies represented generally fall into two groups. They cluster around the two approaches to EDPs. One group focuses on resolving

difficult emotions and the other on eliminating dysfunctional behaviors and reactions. Mindfulness, Emotion Focused Therapy, Exposure and EMDR (Eye Movement Desensitization and Reprocessing), to name a few, are mainly aimed at helping with distressing emotions. On the other hand, many forms of Cognitive-Behavioral Therapy primarily target the dysfunctional behavior, itself.

Some therapies do both. Traditional psychodynamic therapy works both with emotions and with distortions of relationships and thinking, but tends to pay less attention to behavior. A third group of therapies, including "third wave" cognitive-behavioral approaches do both. Dialectical Behavior Therapy, for example, goes back and forth between distressing emotions and dysfunctional reactions.

Dysfunctional patterns range all the way from–say–avoidance of commitment in relationships, to gambling addiction. Obviously therapy for these very different problems, or any other EDPs, will not look or feel the same. So you can see that, even though all EDPs have some common factors, it doesn't quite make sense to use the same therapeutic technique for all of them.

Modular Therapy

This term has been used since at least 2004, when Bruce Chorpita at UCLA wrote about using a more flexible approach. Instead of following a single protocol for every part of the work with every patient having a diagnosis of anxiety, therapy was broken down into units and therapeutic strategies chosen for each specific unit. He called this Modular Therapy. Using a similar approach for a broader range of problems, we will break down the work of therapy into an approach for each EDP as it comes up. As we identify specific EDPs it will make sense to ask what are the best tools for the emotional and the behavioral approaches to each EDP. Not every patient-therapist pair will pick the same methods, and each EDP

they encounter may be different. They will hopefully choose tools according to what will work best, what is most comfortable for the patient, and what is familiar to the therapist. In that way, treatment for each EDP can be seen as a *module* of therapy, hence, Modular Therapy.

This may seem obvious, but it represents a huge change from the traditional organization of treatment where the patient is chosen to fit the method and the therapist applies more or less the same method to every phase of the work.

In the next chapter, we will go further to make sense of how and why we humans so regularly develop EDPs, what they are made of, and how they can be overcome.

Three

How We Avoid Affects

Now it is time to look at how affect avoidance spawns EDPs and how facing feelings is what cures them. Note that I have used the word *affect* to denote emotions that we can actually feel, emotions that come "into the room," accompanied by visceral sensations. This distinction is highly significant because it is only when feelings are activated in this way that they become available for healing. When I say *affect*, it is only to refer to feelings you actually feel. I use the words "emotion" and "feeling" to refer to any feelings, conscious or not, anticipated or experienced.

We'll start from the point of view that the mammalian brain is an organ whose function is to control behavior for the survival of the species. Mammals have been around for more than 100 million years and this organ has served quite well in helping our ancestors survive and thrive under changing conditions. Then, along come humans, who not only have awareness, but also the ability to reflect upon themselves and their decisions. Unlike animals, who seem doomed to do whatever feels best, we are (sometimes) able to listen to our ideas when they tell us to go against our natural instincts.

We all have had the experience of wanting to make ourselves do something different from what seems natural. It is easier to follow what

feels comfortable and less painful, but we do have the ability to decide. With some effort, sometimes a great deal of effort, we are able to wrench ourselves out of our "comfort zone" into something unnatural that we have decided is in our own best interest.

Surgery is an example. We may dread going under the anesthesia or feeling pain but we consider thoughtfully what is best for us. If we observe carefully, we can see that our natural instinct is to go towards comfortable feelings and away from painful ones. Feelings like pleasure, fear, comfort, pain or pride strongly influence our decisions. We commonly speak about having to decide between our "head" and our "heart."

What this means, is that our mind is a source of emotion that tugs on our free will. On the other hand, we are able to "think" about things and develop ideas that are independent from our feelings. Our will is, in fact, free because we have a choice of whether to follow our emotions or our intellect.

This ability to use our free will to go against what feels comfortable gives us humans some remarkable capabilities. For example, we can, and many among us do, push ourselves to run 26 miles when the brain says it's a really bad idea. When we go against our instincts, as in the case of the marathon, there is quite a bit of pushback from our brain. When we go ahead, against our brain's better judgment, we experience decidedly uncomfortable feelings. Our brain seems strongly focused on survival and, on that basis, may disagree with us about what is best. Perhaps the more we, as a civilization, have the choice of designing our lives, the more often we have ideas to do weird things such as jumping off cliffs. Actions like these take us far from our comfort zone, but may allow us to discover pleasures we would never have known otherwise.

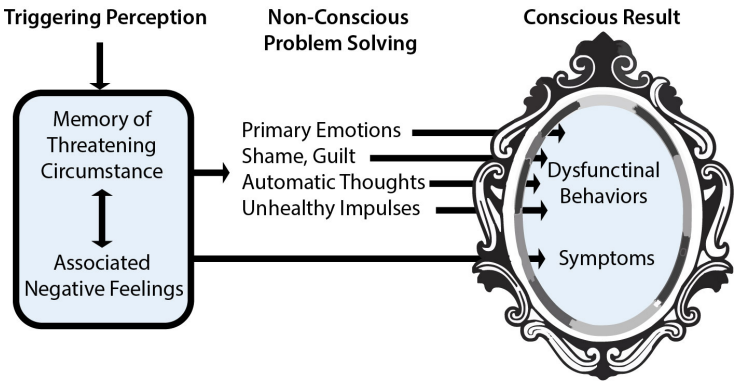
In most of the examples above, the brain's idea of what is good, as measured by the feelings it sends into our consciousness, has to do with physical survival. But we also have sophisticated instincts related to social life and other higher functions. Our survival as a species has

depended on he social cohesiveness that makes united action possible. As the tools of survival become more elaborate and social, it takes not simply a brain, but a mind (I don't try to make a sharp distinction between the two) to steer us in the "right" direction. Using the same or similar feelings sent into consciousness, the mind influences complex social decisions as well. Think how often we know that having a difficult conversation is the right thing to do, but avoid it because our brain is anticipating discomfort and telling us it would be better not to face possible social consequences.

All this is to say that being human involves a certain amount of tension between what our mind wants us to do and what we, using our ability to think and our free will, decide is best. Now let's apply this perspective to psychotherapy. Those Entrenched Dysfunctional Patterns–EDPs–represent glitches in the mind's software. They are the times when what our mind thinks is good for us is contrary to what we believe is really best. At those times, our natural instincts, using emotions, "try" to steer us in a direction contrary to our best interests while we do our best to go in a direction that we believe is wiser and better.

The Complete EDP

Now it is time to introduce a fuller picture of the EDP. All of them start with a circumstance we recognize by matching perception with a stored memory trace. In all of them, that circumstance is paired with a negative feeling that we dread and naturally try to put at a distance. The third element is a pattern of avoidance that works to distance us from experiencing the dreaded feeling. Below is a diagram:



Entrenched Dysfunctional Pattern (EDP)

To summarize, activation of an EDP starts with a perception that triggers memory representing some threatening circumstance. As the memory is activated, so is an associated negative feeling. The mind then goes to work "figuring out" how best to distance the feeling. This problem solving is non-conscious, but produces conscious results consisting of voluntary behaviors and involuntary symptoms. In addition, the mind sends influencing signals, i.e. fear, shame, automatic thoughts and impulses into consciousness to steer our choices of behavior.

Affect Avoidance

The common origin of all EDPs is the basic instinct to avoid painful, overwhelming, and uncomfortable affects. The idea that affect avoidance is the root of our psychological problems is an old one. Perhaps among modern thinkers, the one who has done the most to identify emotional distancing as the root of problems and emotional healing as the key to health is Les Greenberg, the originator of Emotion Focused Therapy.

Here, I want to avoid possible controversy. Talking about "unconscious emotion" could raise some scientific eyebrows. The truth is that no one knows quite what goes on in the "black box" where a great deal of mental processing goes on. What is clear is that the mind has a highly

developed ability to *anticipate* trouble. Among the troubles it is capable of anticipating is the conscious experiencing of unpleasant affects. So when the diagram indicates that the mind associates a "negative feeling" with recognition of a certain circumstance, what this really means is no more than that the mind has some way of anticipating that the presence of that circumstance could lead to an unpleasant conscious emotion or *affect*. Therefore the mind "goes to work" to develop a plan for evasive action. Where our free will might "foil" evasive behaviors, the mind is also capable of putting pressure on free will by sending thoughts, impulses, and feelings into consciousness to influence our decision making in the direction it deems best.

When the mind experiences or anticipates a difficult affect it uses the tools available at the time develop strategies for distancing that feeling. As patterns of avoidance are invented and become part of our remembered repertoire, they tend to be used repeatedly. Strategies invented in our early years may continue to be used and bear the characteristics of very young thinking. At first, the pattern works as part of our natural and healthy defenses to protect us from pain, discomfort, or from being overwhelmed. Eventually some of our protective patterns may become dysfunctional. This can happen for three reasons.

1. Inherently primitive patterns: Those that are invented early in life, when psychological development is quite young, often represent desperate, life-and-death measures, taken without regard to cost. Moreover, limitations in the child's cognitive abilities and understanding of the world make for simple, even primitive, strategies. For example, very early in our psychological development, we are unable to identify clearly whether anger belongs to ourselves or to others who might be angry at us. If circumstances make anger a dangerous experience, a child might learn to misidentify his or her own anger as coming from outside. The result is a perception of persecution. Do you recognize an EDP? The

mind has gone to work to invent an automatic thought that changes the perception of reality so as to distance any awareness of feeling anger, thereby warding off the affect (fear) that would otherwise accompany awareness of feeling angry. The result is a distortion in the perception of reality: "I'm not angry, you are."

This pattern works to distance the fear associated with feeling angry, but is immediately dysfunctional because it causes a distortion in the perception of reality and alienates those wrongly accused of being angry towards the child. This is an instance of an EDP that is inherently dysfunctional because at that early point in development, the mind doesn't have a healthy way to protect itself from the threatening quality associated with anger. Many other early EDPs work at the expense of accurate perception of reality, which almost always carries a high cost.

2. The danger loses relevance: A second way that avoidance patterns can become dysfunctional is when the original situation has changed. A person raised in a chaotic or abusive home may learn self-protection by always being on guard and not trusting. During childhood, when there is no choice about whom to depend on, this may be a wise stance. Later on in adulthood, when we are able to choose on whom to depend, the danger of betrayal is not so great while the cost of constant guardedness and mistrust is much greater.

3. Developmental arrest: A third way protective patterns become dysfunctional is thorough avoidance of uncomfortable experience. Growth and development happen when we practice new behaviors and experiences. The effect of avoiding experience because of anticipation of pain is that we may fail to develop certain skills or maturity. The result is that growth that might take place does not. Skills may not be available until years later when, with luck, we may find ourselves ready to pick up the trail of development once again.

Resisting Positive Change

In general, when therapy encourages us to let go of a once-protective EDP, our mind senses that removing a protection could put us in danger of experiencing a painful affect. In this way, change, itself, triggers anticipation of an uncomfortable affect. Naturally, then, our mind goes to work to steer us in the opposite direction, that is, further away from healthy change. The mind approaches this mistakenly perceived challenge by inventing or using what, in effect, is a new layer of EDP.

The original layer was to protect from anticipated affect. Then our therapy suggests letting it go, which raises new alarms, and the mind invents a new EDP to block our effort at getting healthier.

These, "anti-therapy" EDPs again have the same three elements, this time, aimed at resisting the positive changes promoted by psychotherapy. The triggering circumstance is change itself. The dreaded emotion is anticipated discomfort from change, and the avoidance pattern is anything that will put off having to change. Therapists sometimes call this "resistance," though it is not anything we do on purpose.

Layers of Avoidance

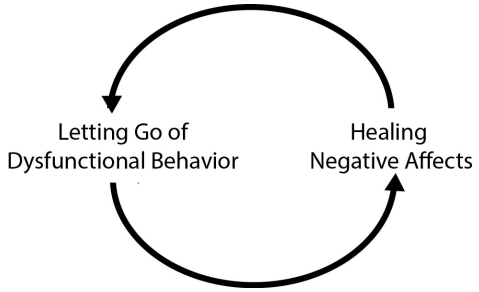
As you can see, our mind naturally produces layers of EDPs to keeping us away from anything that might be anticipated eventually to lead to painful, overwhelming or uncomfortable affects. Our psychological problems consist of several layers of EDPs, each one serving to cover up emotions that might leak out from the layer below. In the end, whether an avoidance pattern began life as a way to distance from an original painful feeling or as a means of resisting change is not important. Each layer has the same origin, distancing from painful affects, the same life-limiting disadvantages, and the same ultimate cure, letting go of the avoidant pattern and facing the feeling.

Each patient tends to develop a repertoire of mechanisms for avoiding difficult feelings. The earliest ones bear the stamp of whatever developmental assets were available at the time. Later means of avoiding affects, for example use of substances, can employ more adult skills and resources. Whether they are invented by children, by teens, or by adults, EDPs still pose a challenge to therapy.

Cyclical Therapy

As discussed earlier, there are two approaches to any EDP, the emotional and the behavioral. We can start by working to disconnect the difficult emotion from the triggering circumstance, or we can work behaviorally to eliminate the dysfunctional pattern. In therapy, we often go back and forth between the two. Therapy follows a cyclical pathway. This is because change in emotion often makes possible changes in behavior, while behavior change tends to uncover emotions. Treatment alternates between helping people heal painful feelings and working with them to let go of dysfunctional patterns of behavior. As each part of the work is successful, it is likely to lead to the other. Healing painful feelings reduces the need for an avoidance pattern and facilitates its elimination. Eliminating a dysfunctional avoidance pattern may, in turn, expose uncomfortable feelings, making them accessible to healing.

Marsha Linehan has described this alternation as a “dialectic” in her Dialectical Behavior Therapy. Paul Wachtel uses the term “cyclical Psychodynamics” to describe a similar alternating pattern:



With the emotional approach, the objective is to heal the painful feelings to the point where they no longer pose a threat. As discussed in Chapter 1, both extinction and reconsolidation, the two healing mechanisms for painful feelings, have both been shown capable of removing the dread from perceived circumstances to the point where recognition no longer triggers a visceral reaction. For this to happen, both healing mechanisms require that we fully re-experience the painful feeling, and both require a context that "disconfirms" the association of the circumstance with danger.

Where can we find both emotional healing and disconfirmation of danger? It is in the safety and empathic connectedness of the therapeutic relationship. This context of safety becomes newly associated with the triggering circumstance instead of the original context of danger. Once the synapses are reconfigured, reminders of the circumstance no longer evoke the dreaded feeling or require avoidance patterns to achieve distance.

When treatment takes the behavioral approach, starting with change in dysfunctional behavior, then the therapeutic relationship works more as a source of clarification that change is needed and motivation to do the work. This is equally true for the relinquishment of old dysfunctional patterns and the adoption of healthy but unfamiliar new ones. Along the way, any uncomfortable affects are brought to consciousness are addressed using extinction or reconsolidation as described above. These

feelings can appear before, during, or after changes in dysfunctional patterns, and should be worked with when they cause distress.

Given our intense instinctive avoidance of uncomfortable affects, we tend to resist both facing our feelings and changing our patterns of avoidance. No matter which way we approach peeling off the next layer of dysfunction, we tend to encounter instinctive resistance. This is one of the reasons why dysfunctional patterns have such a strong tendency to remain in place. This may sound pessimistic, but one thing that gives therapy the advantage is that we tend to use the same EDPs over and over. Each person has a repertoire of avoidance mechanisms and a set of dreaded feelings but they tend to be limited in number. While the twists and turns of our avoidance may be extensive, it is within our reach to observe and learn all the moves. Then we are in a better position to use the therapeutic partnership to work with each EDP, one at a time.

The better we know the dance, the easier it becomes to repeat our first successful experiences of facing feelings and those of letting go of avoidance. Hopefully soon, both therapist and patient become familiar with the dance, and are able to proceed with more ease and confidence.

One Model for Many Therapies

This model of pathology and healing is potentially compatible with all schools of psychotherapy, ranging from psychoanalysis, to experiential therapies, to cognitive, and behavioral therapies. Different therapies may emphasize different aspects of the process, but both the behavioral and emotional components exist in all and the underlying change processes are universal.

As each EDP comes into view and we choose the emotional or the behavioral approach, we encounter a clearly identifiable therapeutic task. These tasks lend themselves to a modular approach in which a match is sought between the task and the method used. With this precise under-

standing of therapeutic work, we can better choose between available techniques. Each school of therapy represents a brilliant answer to one or a few therapeutic tasks. By pooling the wisdom of many schools, we can begin to tailor the approach to the task at hand, recognizing that we will need to shift our approach as different tasks come into view.

With this understanding of EDPs and the psychic work needed to unravel them, the way is cleared for escaping the limitations imposed by using a single set of techniques throughout treatment.

Four

How to Strengthen Any Therapy

Now, dear reader, you have a pretty good idea of the tasks of therapy. You are aware that at any given point, you are dealing with one or another EDP. Moreover, you are approaching it either from the direction of healing troublesome emotions or from the direction of trying to become healthier in your behavior, values or thoughts. As you engage in each module of therapy and share your thoughts and feelings with your therapist, you will find yourself approaching your EDPs from one or the other direction. At any particular moment, you will be:

- Feeling something but wondering what it means
- Dealing with proximity to a strong feeling
- Reacting to a circumstance and, hopefully, thinking about how healthy or unhealthy your reaction is and what might be a better way.
- Working on changing an unhealthy pattern.
- Trying to understand the reasons behind a reaction

As we turn towards helping you understand and resolve your personal EDPs, here are some general ideas about how to get more from working

with your therapist to adopt healthier behaviors and to face your difficult feelings.

1. Be an Educated Consumer

Times are changing fast. The more we understand about ourselves and about how therapy works, the better the results will be. If the therapy seems to be wandering aimlessly, I would want you to make an issue out of that. Sometimes therapists are trained in a method, but go through the moves without understanding how they might connect to progress. The mind is very good at keeping things the same, so it can easily happen that good intentions still don't bring about change.

An older style was for therapy to be a bit mysterious and the therapist an authority, not to be questioned. Today, this raises concerns about whether the therapist is using the aura of mystery to cover up uncertainty. All therapists experience uncertainty often, so one who is able to own his or her doubt is being more honest. At least in the 21st Century, admission of fallibility and humanness seems more genuinely reassuring.

Therapy should have a focus and direction, or at least a method that heads in the direction you want and need. Structure helps make you and your therapist accountable and allows monitoring your progress.

Traditional talk therapy can be open-ended and free form, but in that modality, your own mind should be providing the structure. It does this automatically as tension mounts between your desire to move towards health and your mind's many ways of avoiding uncomfortable feelings anticipated along the way. You will be able to identify both movement towards health and the inner resistance that opposes it. Especially in more intensive therapy, as detailed in Chapter 8, it is good to think of the part of you who is afraid to get healthier as a child within, who wants the therapist/parent to make everything better rather than face painful feelings. You, the adult will do well to approach that part of yourself just as

a parent would, with compassion and understanding but firmness and clarity that letting a child run your life is not a good for either of you.

In more structured kinds of therapy, as an educated consumer, you will be more able to monitor your progress. Your therapist will probably welcome a partnership in which you show your investment in managing the process. Ask questions. Discuss your ideas about what is going on. He or she will hopefully have a rationale for what you are doing, but there will always be questions and open items that you can help to clarify. The last thing to do is passively wait for the therapist to know everything. You know more about yourself than anyone, and your feelings about what "resonates" are among the most valuable indicators of what is going on in the invisible part of your mind.

2. Disclose, Disclose, Disclose

It is critical not to hold anything back, even if what you would rather not tell is painful and embarrassing. This includes things you do, as well as thoughts and feelings. In order to make this a black and white issue, I like to use the word "disclose." You either disclose or you don't. There is no in-between.

Shame damages many therapies. I understand that it can be excruciating to admit to actions and feelings you are sure your therapist will judge. It is more likely that the disapproval belongs more to you than to your therapist. Not telling about a feeling prevents healing. Not telling about an action blocks the possibility of learning and change.

Why such shame? We all learn in childhood to put a high value being "grown-up" and in control of ourselves. The consequence is that we feel shame about anything that might look "immature" or suggest lack of mastery. Actually, as I will discuss in Chapter 8, one of the most positive ways we have of protecting and preserving ourselves at times of deprivation or adversity early in life is to leave a part of ourselves behind.

Instead of maturing in a distorted way, this partial "inner child" stays young and undamaged by the ugliness around us. He or she holds onto the hope of one day filling the empty places. Of course this hope is young and naive, but the good news is that it has kept that part of us untarnished and ready for a more mature acceptance of things that can't be fixed. So there is no good reason to be ashamed of harboring childlike wishes and needs. The way to resolve them is to bring them gently and compassionately into the light of day. Full disclosure with a caring and empathic therapist is the best way to do this.

Shame is the friend of your enemy. It comes from disapproving attitudes that you have internalized. Those, in turn, come from negativity that you took in from some unkind circumstance. Even if it is about something really destructive that you have done, the shame still needs to heal, and that will help you heal.

If you are paralyzed by shame, here is a trick for getting unstuck: Leave aside the daunting topic and talk, instead, about the fact that you are uncomfortable about disclosure. Making shame, itself, the subject will help you inch towards eventual disclosure. Another trick is to enlist your conscience as an ally. If your conscience insists on honesty, then consider omission an act of dishonesty and tell yourself that full disclosure is a duty.

What if your therapist doesn't react in a professional manner? Competent therapists should be enough at peace with themselves to be able to handle your feelings and acts, but I have heard enough stories about therapist's inappropriate reactions to be clear that disclosure can be a genuine risk. Here is why it is a good idea to take the risk anyway, and do it sooner rather than later:

I knew of a case where a patient disclosed something personal and the therapist responded in a mildly judgmental way. Sadly the patient was so dismayed by the reaction that he did not disclose how hurt he was. He silently withdrew his trust and the rest of the therapy became a

hollow sham. The patient lost faith but failed to confront the therapist. The therapy effectively ended and a needed opportunity for growth was lost until years later.

If your therapist is not able to deal with something about you, then, eventually, that limitation will cause trouble in the therapy. It is far better to know early that this is not the therapist for you. Then you can cut your losses instead of investing more in a therapy doomed to failure. You might also be surprised to find your therapist ready to recognize an error and to work it out with you. Maybe you both have a contribution. In that case, partnering to sort out what happened will put you both on a much better footing. It just doesn't work to hold onto a bubble of illusion that everything is OK, when it is not.

So, once again, I can't overemphasize the importance of finding a way to overcome shame and talking about those tender feelings, fantasies and truths about your life.

3. Work Hard to Identify and Eliminate Dysfunctional Patterns

Entrenched Dysfunctional Patterns won't melt away by themselves. Working to identify and change them will, in itself, improve your life. Furthermore, as you have success in removing these barriers to feeling, you will, at last, have a chance to encounter and detoxify painful feelings that you have needed to face for years. Even though you are accustomed to carrying your unhealed feelings, doing so takes energy that could be used to make better use of the life you have been given.

Your mind can be expected to come up with any number of excuses for staying the same, and thereby keeping your dreaded feelings distant. One of the more common ways is to tell yourself that the problem is outside yourself and that you have "no choice" but to follow your old patterns. That may be partially true, but doesn't help much because you

probably can't change the world outside. If complaining about life is a way of bringing your feelings into the therapy room, then that is a good thing. Accessing feelings in a context of safety and empathic connection is the best way to heal them. On the other hand, focusing on unfair things in life can be a way of avoiding the emotional work of acceptance. Cutting the losses you can't undo is the only way to move forward.

I usually disapprove of sports metaphors, but there is one that I can't help but like. Life is like baseball. The pitcher (life) throws pitches at you that are often unfavorable, even terrible. Your job is to let the bad ones go by and swing at the good ones. Those players who manage to hit one pitch for every three times at bat are considered excellent players. In life, your success and happiness depend most on how you react to whatever circumstances life brings. Therapy is to help you let go of the pain of your past losses and improve your success today.

Giving proper importance to dysfunctional behavior patterns is especially important for traditional therapies. In the Victorian Era, therapy was for the upper classes, among whom, inhibition of instincts and impulses was the considered the mark of good breeding. The ideal was not to act. Uninhibited action was for the masses, or that was how people thought. Perhaps because behavior was supposed to be so tightly controlled, little attention was paid to its power to suppress feeling. Therapists were taught never to tell the patient what to do or not do, and allowed themselves only to "interpret" possible motivations behind it.

There were several reasons, most of which are no longer valid. First, the therapist was supposed to be an objective, but blank, observer. This has largely been abandoned as impossible in real life and not even desirable. Second, the therapist might "impose" his or her values on the patient. Yes, it is important to recognize that the therapist's recommendations or even thoughts may carry increased weight due to the nature of the relationship. However, open discussion and informed consent are the

more modern way to take care of this concern. Finally, active involvement in making behavioral recommendations was thought to be "infantilizing," encouraging passivity. However, just as with parents, exercising good judgment as to what information might be helpful and what is stifling is a better solution than applying a blanket rule.

In today's world of "Just do it," dysfunctional behavior is a much bigger element in our problems than ever. And behavior is extremely effective at keeping feelings from being felt. For example, systematically avoiding assertive behaviors could be a very effective way of avoiding anxiety or guilt associated with competitiveness. Entrenched behaviors don't usually disappear on their own. Being in therapy and simply waiting for a behavior pattern to change will slow or even stop the process.

Because the amount of feeling behind each dysfunctional behavior can be great, resistance to changing behavior patterns can be very strong. If you have trouble letting go of a dysfunctional pattern, this should be an active subject with your therapist, as you work together to find ways to overcome your inner fear of change.

This area is also one where unnecessary and dysfunctional tension can develop between patient and therapist. The tension should be between you and another part of yourself. If the therapist becomes too invested in change, as opposed to helping you in your struggle with yourself, you may experience what I call "cat and mouse." The therapist (cat) becomes responsible for the good behavior and you (mouse) become the champion of bad. Usually the mouse wins. Therapists should know not to allow this dynamic. As argued by Miller and Rollnick, it is the therapist's job to "roll with resistance," becoming an observer of the interaction, rather than a participant. Then the therapist can help you identify your own ambivalence and work productively with it.

Pressure or "brute force" directed at yourself is usually not the most effective way to change. It is especially unhelpful to have a critical or negative attitude towards the young part of yourself that is trying to pro-

tect you by keeping everything the same. Someone wisely said, “When you want a turtle to poke its head out, don’t bang on its shell.” Don’t be harsh with yourself. It will almost always be more efficient to explore gently the feelings and motivations behind the behavior at the same time that you work on changing the pattern itself.

4. Notice Avoidance of Feelings

Avoiding feelings is very natural and we have many ways to do so. While this is instinctive and may have been necessary to keep us from being overwhelmed, now it blocks the healing that we really need. It is only when feelings become activated as consciously experienced affects, that is, palpable in the room, that they can heal. Furthermore a safe relationship with an empathic therapist-witness is a rare and valuable element in allowing healing to happen. So it is imperative to bring your feelings into your sessions. That is why affect avoidance is the number one enemy of progress.

Avoiding feelings is too easy to do. All of us have ways to avoid uncomfortable feelings and they all work against progress in therapy. Identifying our avoidance patterns and talking about them, as well as trying not to use them, all move the process along. The point here is that avoidance of feelings is not always obvious. It is so common and automatic that, without our active participation in bringing feelings into the room, a therapist may not be aware enough to help.

For example, as soon as a feeing comes up, we may engage in philosophical talk to make the affect disappear. “I feel anger towards that person,” then a moment later, “But she really did the best she could.” That nice phrase is not an expression of ultimate acceptance, but a way to distance the feeling before it has a chance to bloom. So noticing your avoidance mechanisms and “telling on yourself” to your therapist will do a great deal to help you face what you need to. By mentioning an avoid-

ance mechanism, you enlist your therapist to help you stay with the feeling long enough and with enough intensity to heal. Therapists are attuned to avoidance of feeling, but there are many things your therapist may not notice or be aware of.

5. Talk About Your Therapy

Talking about the subject of your therapy is a bit unnatural. Doing so feels "out of the box" and may even seem against some imaginary rule. In social conversation we usually don't talk about the process but in therapy this is one of the best ways to gain access to background information where important nonverbal, emotional interactions take place. Your physical doctor might take offense at your questioning his or her exam technique, but your therapist should welcome your interest. The difference is that the physical doctor holds the roadmap of your body and physiology. When it comes to the intricacies of your thoughts and feelings, you are the one with the most insight. It is in the therapy interaction that you are most likely to become aware of the agendas and feelings of your child within. This is also the realm where fantasies, questions and feelings about the therapist tend to lurk.

Talking about the therapy (metacommunication) is where you can learn about how you both participate in the therapeutic relationship. This relationship is critical for healing of painful feelings, because the context of safety and attunement is what disproves or "disconfirms" the erroneous generalizations you may have learned long ago.

I'm sorry it is so hard to talk about feelings towards your therapist, but doing so is critical. The two of you need to honor these feelings together. If your feelings are negative, they are just as important. The only way to sort out what parts of your feelings are contemporary and what parts have to do with the past is to share them and work together. To put

it simply, the work you do together to learn from and to maintain your relationship is essential to the success of your therapy.

The relationship is also a strong source of motivation. We are all human, and quite apart from anything problematic in childhood, we all want to get closer to the therapist and to be understood. These needs can work to motivate you to change, or can become secret, even dysfunctional quests in themselves. Issues in this area are likely to be missed unless you dare to talk about them in therapy, so take a deep breath and go ahead.

6. Monitor Your Progress

Even if you are doing great work on the feelings that an EDP was designed to avoid, dysfunctional behaviors may not just melt away. Habit and impulses may continue to keep a pattern in place even when it no longer serves a purpose. Monitoring your progress is a way to be sure you and your therapist are both on top of the work.

Cognitive therapists are trained to help you do this, but traditional therapists may even be trained to stay away from the area of behavior. If you are left on your own to practice new, healthier behavior patterns, then it is especially important to set up structures such as diaries and rating scales to monitor progress. If your therapist is staying out of this area, I don't think it would be bad to question why.

Personally, I confess that I tend not to use complicated paper and pencil methods, as they feel like a distraction, but I'm not sure that is always right. You are welcome to tell me that you need more structure. What I do insist on is consistently identifying and pointing out markers of change in the course of therapy. This is not only a way of monitoring progress, but also motivates and fosters a larger perspective on the arc of change.

If you are not seeing month-to-month progress, then there should be a good explanation for why not. Slow progress is not necessarily an indication of bad treatment but you deserve to have some clarity about why.

7. Use Therapist Extenders

The original format of psychoanalysis was to meet with the doctor for a 50 minute session five or six times a week. That naturally created a high-intensity relationship on which any unfinished emotional business would soon become superimposed. Since then, most of us have accepted that this frequency is more than most people can afford or really need. I have had successful explorative therapies in a context of meeting once a month. More often, weekly sessions give enough time for interaction but leave a lot of opportunity to work on issues in between sessions.

It is natural to become caught up with daily life in between sessions and to lose momentum that could be developed. You could make notes soon after your session. A diary is another and more intensive way to keep yourself on the job of exploring and changing. Talking about your sessions with a third party can work both ways. It can dilute the intensity of your relationship, and it can be a way to support change. This is something to discuss with your therapist.

The Internet offers tools for keeping your therapy front and center. MyTherapy.com offers a free therapy notepad that is accessible to both of you. I know of one therapist who has each member of a couple fill out an online form to rate their daily level of intimacy. Their instructions are to try, every day, to increase their level of intimacy in several different areas. The result is that the couple's relationship with each other takes on much of the intensity of old-time psychoanalysis. At first things get really messy, then, if all goes well, the couple become closer and more content than ever before.

I have often worked with people who were participating in 12-step meetings. This has almost universally been a positive experience. The meetings are a powerful support for behavior change while therapy provides a place to explore the meaning of the patient's feelings and reactions. As time goes on, sometimes the meetings and sponsor relationship can take over ongoing work towards change of deeply embedded patterns. Not all 12-step groups and members are friendly towards therapy, but usually this can be navigated.

Meditation is another therapy extender. I think meditation has effects not so different from a 12-step group. It is a place for both heightened awareness and emotional healing.

Split treatment with a physician or prescriber providing medication and a therapist doing the talking has become something of a norm in the US. Most of the time, I think this is unfortunate. Psychiatrists and other physicians or nurse practitioners are expected to know a human being well enough to monitor powerful pharmacological treatments with a five-to-ten minute exchange. "You're doing OK, right?" Furthermore, with this kind of schedule, real communication between prescriber and therapist is rare. Perhaps half of the effect of medication is psychological, and can't be understood or taken into account without a more substantial relationship. Medication often takes on a meaning of being taken care of, or neglected or both. How these meanings manifest themselves has a profound effect on the person and the process. So, sadly, many therapists are left isolated to make the best of a situation in which important parts of the overall treatment are outside of their control.

What about books and workbooks? Yes, those, too, will heighten your awareness of the process and block your mind's tendency to put uncomfortable things in the background.

Patients often mention healthy eating and exercise. As ways to care for oneself, these are very good. They will not make dysfunctional patterns disappear, but there is one effect of exercise that is important to

note. Strenuous exercise produces endorphins. These have been shown to have antidepressant effects on the emotional brain, as explained in the section on depression in Chapter 7. Exercise can improve depression, while stopping a regular exercise program can promote depression.

Using extenders will increase the amount of focus and energy in your therapy, thereby enhancing your ability to identify and resolve EDPs. As long as the intensity is manageable by patient and therapist, then it only helps in seeing and making sense of dysfunctional patterns and how to change them.

8. Make Use of the Scarsdale Psychotherapy Self-Evaluation

I developed this 18-item questionnaire, reprinted in the Appendix, to help highlight areas where therapy might need tuning up. It has three sections, first the relationship, then the primary tasks of therapy and finally, an assessment of safety. The numerical score will not tell you exactly how you are doing, but areas with low scores should be a reason for thought and, even more important, discussion with your therapist.

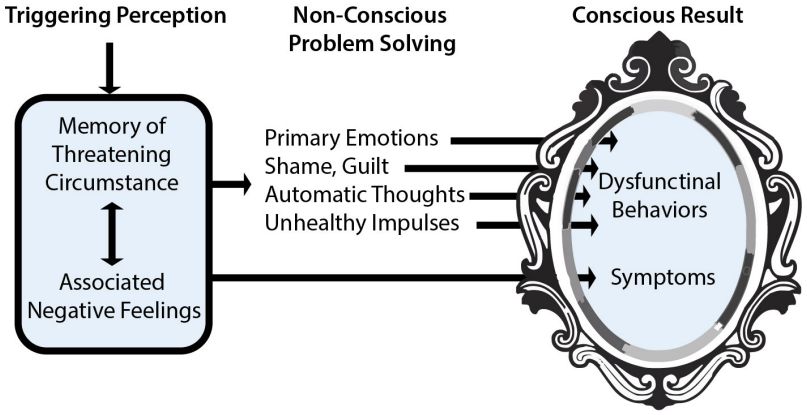
What's Next?

The first three chapters were aimed at giving you a framework for understanding EDPs and how they work. This fourth chapter focused on principles that apply to therapy in general. The next three chapters will help you identify and understand your own personal affect avoidance patterns. The full range of EDPs will be divided into three groups, those behavior patterns that are subject to free will, those that exert influence on our free choices and those involuntary and unwelcome products of mind that we call symptoms.

Five

Dysfunctional Behavior

This chapter is about those dysfunctional behaviors that are freely chosen, as opposed to influencers and symptoms that come upon us whether we like it or not. Please allow me now to repeat the earlier summary of how EDPs work: Activation of an EDP starts with a perception that triggers memory of a potentially threatening circumstance. As the memory is activated, so is an associated negative feeling. The mind then goes to work "figuring out" how best to distance the feeling. This non-conscious problem solving produces results consisting of voluntary behaviors and involuntary symptoms. In addition, the mind sends influencing signals into consciousness to steer our choices of behavior via free will. Here, again, is the diagram:



Entrenched Dysfunctional Pattern (EDP)

When we choose to do something dysfunctional we are not likely to have any idea that its purpose could be to avoid feelings. What makes avoidant behavior patterns so important in therapy is that once we become aware of their purpose and how dysfunctional they are, we gain the option of going outside our comfort zone and choosing healthier ones instead.

Each type of dysfunctional behavior has a distinctive look and feel in the context of psychotherapy. Patterns in each group generally respond to similar treatment approaches, which is the basis Modular Therapy. Much research has yet to be done to clarify which approaches are best for specific avoidance mechanisms. I will offer some suggestions about possible ways to overcome each type of EDP, however these are intended as ideas or starting points for you and your therapist rather than a complete list or cookbook for treatment.

Before we start, let's take a brief look at how we can allow ourselves to form opinions about the non-conscious processing of the mind.

How Can We Know?

Much of what the mind does to avoid problematic feelings is invented or designed in that part of the mind that does not appear in our window of consciousness. Just as automatic thoughts and impulses are the conscious products of this hidden part of the mind, the logic or rationale behind avoidance patterns is also hidden. So how can we know that the avoidance mechanisms that follow are actually designed for that purpose? I will offer three reasons for this conclusion.

The first is to think of this non-conscious part of the mind as a "black box." Engineers use the term for devices that can't be observed directly. Instead, they analyze what goes in and what comes out. From these inputs and outputs, they draw inferences about the workings within.

Therapy can be done without asking why, but for most of us, having educated guesses or hypotheses is both satisfying and helpful in motivating ourselves to do the hard work.

Thinking of the mind as a black box, the inputs, are our perceptions of circumstances, internal and external. The hidden mind's outputs or products are the things that pop into consciousness, namely, behaviors, influencers, and symptoms. For me, the most illuminating opportunity to observe these inputs and outputs has been from working with people with addictions. When they are in early recovery, we can often see that missing the drug is the input. The mind is craving the feeling of the drug or dreading withdrawal. With these things being the most salient inputs, we then look at the outputs that appear in consciousness.

When the addict says, "I'm sure I can handle this with willpower alone," we know this thought is unrealistic and it is a small step to guess that the mind is sending up an automatic thought to influence the addict to refuse the outside help that is offered, thereby essentially guaranteeing relapse. It is this kind of thought that has convinced me that the best explanation of many of the products of the mind that enter consciousness is avoidance of painful, overwhelming and uncomfortable affects. The same kind of black box analysis over years of experience is what lies behind my understanding of the wide variety of EDPs that follow.

The second reason is "resonance." When patients tell us that an idea "resonates," it means that words have activated certain neural networks in the brain, and that those networks are associated with a feeling of recognition. When some ideas produce a feeling of resonance and others don't, it gives the observer some confidence that the ones that resonate are likely to be closer to the invisible contents of the mind than ones that don't resonate. Again a long tradition of building and testing hypotheses based on reports of resonance gives confidence that the method works.

The third and last line of evidence is pragmatic. When we hypothesize about the mechanisms described here and use the hypotheses to

direct therapy, if the result is that previously entrenched symptoms melt away, then we have further confirmation that the hypothesis was correct. The experience of many therapists over many years would support the thought that we are often, if not usually, on the right track.

So it is not unreasonable to imagine that a thought that has resonance or feels "right," to you corresponds to something that is real even if it is not directly observable.

Eight Behavioral Avoidance Patterns

Here, then are the eight "building blocks" of active affect avoidance patterns. Together with the channels of influence and the non-voluntary symptoms described in the next two chapters, we will have examined all the types of EDPs from of which our problems are constructed.

1. Simple Avoidance

When difficult feelings seem too painful or hard to face, we may consciously and purposefully choose to avoid them. Do you sometimes find yourself saying, "I don't want to talk about that?" Are you aware of more subtle, but still voluntary ways of distracting yourself, numbing or steering clear of reminders that might trigger difficult emotions? Simple avoidance applies not only to primary feelings like fear or pain, but also to secondary feelings such as shame. In fact, in therapy, guilt and shame are probably more often the focus of avoidance than other feelings. When we do avoid them, of course both healing and growth are blocked. When we find the courage to face difficult feelings then the neural networks representing them are activated, and healing can begin. As describe earlier, one healing mechanism, *extinction*, requires repetitive sessions and does not last without reinforcement, while the other, *reconsolidation*, requires strong activation and holding the feeling at full

intensity for a few seconds or minutes. But once that happens, the healing is permanent and effortless. While it can take a great deal of work to become ready to face a dreaded feeling, usually the dread turns out to be far worse than the actual experience. You may feel drained afterwards, but you will probably feel even more relief.

Working with simple avoidance is perhaps the essence of trauma treatment. Traditional approaches emphasize a supportive, empathic relationship that maximizes safety and encourages patients to take the risk of feeling. Techniques that control the level of affect, such as EMDR (Eye Movement Desensitization and Reprocessing) help reduce overwhelming affects into smaller, less threatening chunks. DBT (Dialectical Behavior Therapy) also includes techniques for making too big emotions less threatening.

Recently Mindfulness has been promoted for healing difficult feelings. This is helpful for many difficult feelings, especially the ones that go with every day life. My best way of explaining mindfulness is "surfing the feeling." Instead of being tumbled around by a wave of feeling, you can ride it. Feel the energy build under you. Look down on the wave, knowing it will take its course, first growing but eventually petering out. This perspective is the essence of mindfulness, whether it is in the course of your sessions or alone.

The fact that mindfulness is something you can do alone raises an interesting question. If mindfulness doesn't require the presence of an empathically connected witness or therapist, then do you really need a therapist to detoxify painful emotions? First, mindfulness, even when you are alone is a very connected state of mind. It is a state where the individual experiences him or herself as a part of something much bigger. This state of connection provides the sense of safety needed to counteract or erase fear memories. For the most serious traumatic feelings healing may work better with a human presence. Possibly the reason is that the worst traumas are experienced in a state of great emo-

tional aloneness. When a significant component of the recall of trauma is the aloneness, then healing may require the actual presence of a witness to disconfirm that aspect.

What will help you with simple avoidance of emotion? First, it helps to believe that facing your feelings will actually be more helpful than traumatic. If you are not sure, then discuss this with your therapist. This is where a therapist whom you trust is really important. Next, it will help to acknowledge all the dysfunctional and energy-robbing things you do to keep yourself far from the difficult memory and its associated feelings. Third, it is important to identify all the influencers you mind is using to discourage you from facing your feelings. These, as shown in the diagram, may be primary feelings like fear, secondary feelings such as shame or guilt, discouraging ideas, and finally impulses that come upon you to act in ways that will keep you away from feeling.

During sessions when you are working on feelings, you will find that your mind wants to skitter away from the feeling. This might be by intellectualizing or by talking yourself out of the feeling. “Well, she did the best she knew how.” This may be true, but its purpose at the moment is to get you away from the feeling. Holding onto a feeling at full intensity for a minute or more is hard, but probably necessary for healing by reconsolidation to take place.

If the experience feels as if, once unleashed, you won’t be able to stop it and it will be too intense, it may help to use EMDR or some of the techniques of DBT to lower the emotional level. You and your therapist can also use more abstract language, a calming voice, and an explanatory narrative to help regulate the intensity.

After you have had an encounter with a dreaded feeling, you will be very vulnerable. Your mind may be looking for reasons to regret your courage and to find a reason for “buyer’s remorse.” This is a time for therapists to be quiet and reassuring, not to try to do more hard work or seek additional insight, especially near the end of a session.

2. Schemas

These are non-verbal patterns of perception and behavior. Schemas, originally studied by Piaget, are learned instinctively to gain comfort and avoid pain, which is why I consider them avoidance mechanisms. Many schemas are positive and helpful. Some start out as positive protections but eventually become dysfunctional. We begin to learn these patterns very early in life, long before language. On the other hand, schemas can be learned or modified at any point in life.

Schemas whose function is to avoid affects will be so automatic that we hardly notice them and may not feel we have any control. You will find yourself doing a behavior without any idea of why. Only afterwards, when you become aware of the consequences, are you likely to realize that it could be a pattern learned long ago. Those schemas that cause problems in life are yet another form of EDP. They are often patterns that affect relationships. Fear of closeness or intimacy can be embodied in impulsive non-verbal behaviors that happen at just the wrong time and powerfully alienate the person you most want to be near.

One particular type of schema is known as *attachment style.* Pioneered by John Bowlby and Mary Ainsworth, four distinct patterns correspond to the way children of about one to two years old respond to a brief absence of the mother. When the child is easily comforted, the style is labeled, “secure.” Once established, these styles tend to remain in place and can last even into adulthood. Patterns such as excessive clinginess or aloofness might be recognizable as “insecure” attachment schemas. Another attachment style is “disorganized” where the person just can’t seem to figure out how to relate to others in such a way that needs are met. This latter style grows out of early experience where the child’s problem-solving mind was unable to find a viable way to relate.

Schemas, like all EDPs, are triggered when the mind recognizes a circumstance, which sets off patterned behaviors to avoid the associated,

difficult feeling. An example from later in childhood might be someone who only received love when ill. Later in life, that person might overemphasize sickness without any awareness that this is part of a learned schema.

Therapy for a dysfunctional schema is a lot like what athletes do to break a bad habit in their game. First we identify the problem. An outsider, like a coach, is often the one to point out that there is a problem. Once the problem is identified, then we try to notice it and substitute a more functional behavior. It may be hard to catch the schema while it is unfolding. A cooperative partner might help, and so also can conjuring up the situation in imagination. Practice, through visualization and/or by actually doing, is important in cementing a new behavior. Unlike problems with sports technique, schemas that serve to ward off an emotion are often scary to let go of, as our mind still anticipates encountering the dreaded emotional experience.

Schema Therapy is a brand of therapy specialized in resolving these patterns. It focuses on three elements. First, identifying and questioning the need for the dysfunctional pattern, second, using experiential techniques like psychodrama to bring feelings into the room. As we know, detoxifying the feeling causes the schema to lose its reason for being and makes change easier. Finally, schema therapy seeks to promote adoption of new behavior patterns to replace the dysfunctional ones. Several authors have written on this subject and can easily be found on the Internet.

3. Reenactment

Helplessness and powerlessness are among the most painful feelings known. From the earliest age, humans as well as other species, when threatened with powerlessness or helplessness will struggle maximally to escape or may enter an equally drastic freezing mode. When we are unable to break out of helplessness, the mind's next defense is to distance

the feeling. Reenactment is a way of doing just that. In effect this means a purposeful, though non-conscious, re-creation of the original, unresolved, situation.

Since reenactments are the product of that part of the mind that is not accessible to consciousness, we can't tell exactly why humans regularly and predictably do this. We can guess that repeating an experience under our own volition counters the feeling of being "done to," even if the reenactment is self-harming. Perhaps an additional motivation is the vain hope that, this time, we will gain the upper hand and have a different outcome. The experience of not having control can be intensely uncomfortable, so it is a reasonable presumption that the overall motivation behind reenactment is to gain at least the illusion of control. Without speculating about the exact motivation, we can say that reenactment generally appears following reminders of a triggering situation where the individual was "done to" and had lost control.

These are complex patterns and quite challenging in therapy. Not only do they originate outside consciousness, but they often come with automatic thoughts to rationalize that the behavior makes logical sense. Reenactment patterns are dysfunctional in an interesting way. Just like the "cliffhangers" in early movies, reenactments set up challenges as difficult as the original, impossible situation. It seems that in the hope of resolving the old unfinished business, the mind seeks to recreate a situation every bit as challenging. Anything less could not lead to a satisfying conclusion.

The result is that reenactments start with high hopes and usually lead to an unsuccessful outcome. This is an important explanation for the pattern of repetitively forming relationships with unattainable partners. One young adult who's father had died when she was nine, would periodically talk herself into taking a road trip which would end with a relationship with an unsuitable man. This would lead to a painful outcome and hav-

ing to be rescued by her mother. Presumably the affect being avoided was grief over the loss of her father, whom she truly loved.

Building awareness, especially of how the pattern is triggered and how it unfolds, can lead to efforts to curb the behavior, which can then allow feelings to become conscious where they can be processed within the therapeutic relationship.

4. Acting Out

This valuable concept covers acting on feelings so as to bypass feeling them. People who go directly from impulse to action tend not even to be aware of the feeling that drove them. An angry person who turns immediately to destructive action or hurting another will hardly feel the anger, and certainly not long enough for it to heal. These patterns could probably be included under the category of schemas. They are automatic and, until we recognize them and take control, largely involuntary. The reason for treating acting out apart from other behavior patterns is that its function of distancing feelings seems to take on a life of its own. It can become a pervasive style. People who do this constantly must often overcome their impulsiveness before they can benefit from the healing processes of therapy.

Not only does acting out take us away from feelings that might benefit from healing, it often reinforces dysfunctional thoughts and values. For example, a person who treats him or herself as unworthy will, thereby, reinforce a negative attitude towards the self. In the same way, acting on hate can reinforce a negative attitude.

The hallmark of acting out is moving so quickly from impulse to action that there is no time or opportunity to notice the triggering circumstance or associated feeling. By not allowing the feeling into conscious awareness, healing is prevented and the pattern is likely to continue. “Autopilot” is one word to describe the habit of going directly

from some vague unease to impulse to action. Once the action is taken, there is often some temporary relief as well as the distraction of dealing with the immediate consequences of the action. Many ugly interactions between spouses fall into this category.

Impulsive, or habitual patterns of action need to be brought to the individual's attention. Where there are rationalizations or resistance to change, Motivational Interviewing, pioneered by Miller and Rollnick is a helpful technique for avoiding a tug-of-war between therapist and patient. This works by encouraging the patent to recognize feelings for and against change. By maintaining neutrality, the therapist can stay out of the way, forcing the patient to recognizing the pros and cons and make up his or her mind. I'll go more into how to change firmly entrenched behavior patterns in the last section on addictions.

5. Hidden Agendas

Irrational behaviors can secretly be motivated by a wish to influence others. i.e. self defeating behavior to arouse attention and pity; inability to forgive while secretly waiting for the other to acknowledge wrongdoing. What distinguishes hidden agendas from schemas is that they incorporate a rationale based on a thought process or idea. Typical of children's problem solving, they seek to influence the "big person," who really holds the power. It is hard to know whether the cognitive part was once thought out consciously or not.

When patterns of behavior seem to be sending a non-verbal message, (I call them "smoke signals") then it might be time to suspect a hidden agenda. How can we tell? The signals are usually strong enough that others sense them and experience a tug, often one that is irritating. It might feel like the other person is constantly seeking attention of some kind, though they sincerely deny it. Perhaps it will help to look at what lies behind hidden agendas and then look at some examples.

I think of these patterns as beginning to appear around age four. This is when the child has a sense of his or her identity and separateness and enough cognitive power to come up with the rationale. There are rudiments of a functioning conscience and values, such as wanting to be "good." At this age, children have the capacity to think and strategize about how to solve problems. They can begin to develop explicit rules to explain how things work or should work.

Usually the underlying drive for hidden agendas is to deal with a need that cannot be met but is too important to relinquish. At this period, especially, we have little ability to accept failure, at least with regard to fulfillment of important emotional needs. They feel like, and may actually be, matters of life and death. Furthermore, acceptance is a skill that may not have been developed. The healthy solution would be to complain in words but these patterns originate in families where words have long since proven fruitless. The fact that an old unmet need is still an issue in adulthood tells us that, back then, no one was listening. Therefore, the only hope of solving the problem was to try to use non-verbal influencing and signaling. Some examples:

A child, and later, adult, may adopt a stance of obviously inappropriate self-blame, presumably in the hope that the parent or some substitute will notice the irony and reform. The tipoff is that failures and even self-harm do not lead to appropriate regret or efforts to change. Some inner need is being addressed. There is a hidden payoff.

Some hidden agendas involve erroneous beliefs, for example, that to be lovable, one must be perfect. The belief, in itself, is a way of clinging to the hope of being loved, "if only I am perfect…" and functions as a perpetual avoidance of the terrible feeling of not being loved.

A child may have extreme difficulty accepting the dysfunction or failure of a parent. At this age of total dependence, parenting is a true necessity. Any failure leads to the implication that no one is there to do the job. At that age, children are unaware of the safety nets that might

actually help them, so the mind's problem solver invents a strategy of hope based on silent communication of needs, of which the adult has no awareness.

To give you an idea of how four-year-olds think and how these thoughts can become incorporated into personality traits, one mother told her son, "When you are eighteen, you will have to be on your own." He was terrified, not knowing if "eighteen" was going to happen tomorrow or the week after. He did his very best never again to depend on his parents and became increasingly, prematurely independent. In his adult career, he became financially very successful, but had trouble in relationships with healthy mutual dependence.

Changing these patterns boils down to the emotional work of grieving and acceptance. One must accept painful realities that once would have been more than a child could bear. What makes this challenging is that the mind still reacts like the child, as if loss of hope equates to death or something close to it. Furthermore, due to shame, there will be strong defenses against conscious acknowledgment of the purpose behind the pattern, and, especially, the need that drives it. For this reason, it may take a good deal of thoughtful and gentle exploration of what feeling might be causing resistance to changing the dysfunctional pattern. Resistance to change is the thread that will lead to understanding.

In Chapter 8 we will look at how it helps to think of the child within, who is still deathly afraid, and to work with the inner child as we would with any child dealing with a serious loss. Patience, compassion and firmness, along with clarification, motivation and empathic support are the ingredients that help in this work.

6. Guilty Quests

The hallmark of a guilty quest is the deeply cherished life goal that somehow never gets accomplished. Paul Simon's lyric goes, "The nearer

your destination, the more you're slip slidin' away." The things that are unique about guilty quests, compared to hidden agendas, are, first, that they are more highly specific, reflecting the cognitive level of a five-year-old's more sophisticated thinking. Second, unlike hidden agendas, they don't appeal to the other person's parental duty, but to adult desires, at least as they looked to a young child.

Wanting to be a great success or a great beauty are the kinds of things that young consumers of fairy tales imagine will win them the love and appreciation they need. When these fantasies are not opposed by the conscience, they remain on the surface where they can be shaped by a growing understanding of reality. The wish to be a ravishing princess or powerful soldier can evolve gradually into an appropriate career choice.

On the other hand, a five-year-old's concept of love may be quite literal and even physical so that it runs into problems with standards held in the child's conscience. This is where shame or guilt produced by the conscience will soon drive the wish underground, out of awareness, and no longer accessible to reshaping. It will then remain in its young form, waiting for the opportunity for fulfillment. A woman in her sixties had never been satisfied with the love she received from any adult man including her husband. Her parents had been much too young, themselves, and preferred partying to the job of parenting. Working in therapy, we gradually clarified her secret and shameful wish for the ideal man who would give her both the love of a parent and that of a husband. It was no wonder no real man was ever good enough for her.

I believe what is unique about these quests is that they are originally intended to be fulfilled *someday,* far into the future. Children don't gain a grasp of the arc of life until around age five. This important acquisition allows them to seek someday solutions to problems of today. The ability to imagine a better future provides a powerful new way to wrest hope from disappointing reality. Unfortunately, some of these ambitions may

place the child in dangerous competition with a parent or in a position of wishing to achieve "illicit" ambitions and pleasures.

The identification and treatment of these EDPs is the classic subject matter of psychoanalysis because they may require long, patient hours and a strong therapeutic relationship to reveal themselves clearly enough to be identified. Patient work with dreams and free association is probably the most effective way to uncover such a pattern. Once they are revealed, empathic understanding fosters reassessment and realignment of immature wishes to fit with adult reality.

7. Arrested Development

Immaturity carries a huge load of shame. That's too bad, because much of the greatest progress in therapy starts with warm-hearted acknowledgment of childlike ways leading to more adult ones. The good news is that we can pick up the developmental pathway after any number of decades as if there were no gap. When I identify an opportunity for maturation, I rejoice because the work is simple–not easy, but simple.

The main impediment to growth is the shame that makes us extremely reluctant to show or even admit to immaturity. Just thinking that we might be lacking maturity in some area generally brings out either outright denial or jokes and embarrassed laughter. In all likelihood the most common reason for failure to tell a therapist something important is the fear of revealing immaturity.

The source of this shame is childhood. When we are young, we all internalize the importance of being "grown up." We feel pride when we are told how "big" we have become, and terrible shame when our immaturity is pointed out. In the next Chapter, you will learn that such internalized values are part of the conscience and don't fade. They remain in place with the same power to generate emotions of shame, guilt,

and pride that they had when we were three or four. This creates a major roadblock to the very do-able tasks of growing up.

Pockets of immaturity are also the type of EDP most neglected in the mental health system. The problem is that they don't fit the definition of "illness." In the US, the dictum is that care is only covered by insurance in cases of "medical necessity," meaning that only illness justifies treatment. Failure to develop or areas of immaturity, which can cause tremendous damage and devastation, are not considered appropriate targets for treatment.

Another problem is that the word "immaturity" tends to conjure up the picture of a global failure to develop, where, in actual practice, developmental arrest usually affects only certain areas of functioning while other areas are quite well developed or even overdeveloped. So, here we are talking about pockets of arrested development that limit our ability to enter into certain situations as effectively as we could. Among the most adept at avoiding maturing experiences are people of above average intelligence. Ask the secretaries of lawyers, doctors, and CEOs how mature their bosses are!

We acquire maturity in a very simple way, by practice. Just as with the resolution of other EDPs, adopting a new behavior brings with it stress and emotions. It is scary to speak to a crowd or ask for a raise. Under healthy conditions, with the needed level of support, anticipated pleasure draws us forward and allows us to metabolize the discomfort and reap the rewards of growth. This is a case of painful feelings being healed by extinction and/or reconsolidation. If there is not enough support, then one of the mind's solutions is to avoid growing and leave development behind.

How do we recognize arrested development? When a more mature, rewarding and successful behavior is absent and a less mature one is used instead. Then we can suspect a history of avoiding the uncomfortable feelings associated with practicing the more mature behavior. Of

course there is overlap with schemas, in that a schema may also consist of avoidance of a frightening, but healthy behavior.

Some patterns with early origins, such as difficulty coping with being alone, can be seen as developmental arrest, where learning to be comfortable with aloneness can be seen as a developmental acquisition. The intense fear of abandonment or being alone associated with "borderline personality" may be more accurately seen as an instance of delayed development than of sickness. More severe EDPs seen in personality disorders and even psychotic conditions can sometimes be understood as arrests in very early development, where acquisitions such as differentiation between self and other may be left incomplete. These are beyond the range of self-help and should be discussed with your therapist.

Another major area of developmental arrest comes from adolescence and young adulthood. In childhood, the goal is simple. We have only to please parents who then shape our environment to our abilities. Transitioning to adulthood, we find that we are on our own in a not-so-friendly world. This is very frightening, especially when the original childhood transaction of pleasing parents and having them shape reality to fit us has not worked out well. One of the best ways to self-protect is to stay a child. We then avoid entering adulthood by avoiding new behaviors or engaging in hard activities. What I see in practice are many teens who opt for a more "laid back" lifestyle, shunning the challenges of the mainstream and falling steadily further behind their peers.

A typical component of the picture is that the young person seems to prefer arguing with parents to engaging with the world. In doing so, they deprive themselves of important formative experiences.

What are some of the developmental skills such young people miss out on? Experience and growth bring advances like impulse control, a sense of personal identity, personal values (as opposed to those of the parents), and the ability to enter into close relationships. When these are

missing or immature, developmental arrest is likely to be the cause, due to nothing more than failure to practice challenging experiences.

The treatment for developmental arrest is to try out new behaviors and tolerate feelings of strangeness, danger and discomfort. Strong support and work with motivation may be needed. Compassion and patience are crucial attitudes towards someone who, for the first time, is facing feelings and challenges that others have long since mastered.

Teen use of substances is a common source of failure to acquire adult strengths. Substance use is one of the easiest ways to cover up fear of facing the challenges of the adult world. Today, this implies a very large population of adults who are lacking important developmental assets. For adults who discover that they are missing significant skills, the world in general has little patience. The understanding and non-judgmental acceptance of 12 step programs is one of the best places to find support for the long and difficult process of catching up. The other is your therapist.

8. Addictions

Addiction is the use of soothing behaviors in spite of serious negative consequences. Those serious consequences mean there has been a failure to self-regulate. The normal mind responds to negative experiences such as embarrassment or harm to career by regulating behavior. In addiction, this self-righting is impaired. Nor does the fact that the destructive behavior is freely chosen mean it is not compulsive. Due to the power of influencers to steer free will (see Chapter 6), people with addictions make “free” choices to act destructively. The essence of addiction is that the mind has decided that the addictive behavior is needed for the survival of the species.

Addiction has a strong biological component. What I see is a spectrum ranging from addictions that are largely driven by a psychological

compulsion to mask some unmet need or pain, to addictions that appear almost solely biological in origin. But wait. Even addictions that are mostly biological in origin soon take over the mind's job of regulating difficult emotions. Healthy coping strategies are lost and, little by little, the addiction takes over whenever there is a need to avoid or modulate feelings. These are the ultimate EDPs.

Compulsive use of mind altering substances or behaviors that give similar chemical rewards, promises to mask pain and fill the emptiness of unmet needs. Unfortunately, these promises are not kept and fulfillment of needs is fleeting. The emptiness keeps asking for more. Both positive feelings received during use and negative ones anticipated from withdrawal gang up to influence free will to continue the use.

The tight connection between the addiction and central brain motivational mechanisms makes resistance to change very strong. For the therapist to step into this powerful force field is perilous. Miller and Rollnick's Motivational Interviewing has the therapist take a very neutral stance, leaving the patient to feel his or her own ambivalence. Were the therapist to attempt to motivate or influence, an adversarial (and unsuccessful) relationship would be the likely result. Beyond the patient's own willingness, a strong support system and simplified, slogan-like ideas are needed to fight the powerful impulses and automatic thoughts that enter the patient's mind.

One of the few neurophysiological forces strong enough to counteract addiction is the brain's need for social connection. This biological force is able to mobilize the mind in powerful ways. If you have doubts, consider the willingness of soldiers to incur mortal danger to support their platoon-mates. Enlisting a small group of supporters, as in a 12-step group, can provide the robust support needed for recovery. The wish for connection is also the basis of planned interventions where the individual must choose between the addiction and valued human relationships.

Conclusion

This completes our review of EDPs consisting of voluntary, or potentially voluntary behavior patterns. In working with them, we need also to be cognizant of how the mind, intent on keeping our EDPs intact, uses four channels of influence that converge on our free will to promote these dysfunctional behaviors. In the next chapter, we will add these to our growing catalog of EDPs.

Six

Your Mind Stacks the Cards

Four Channels of Influence

Our mind is able to influence free will and voluntary choices through the four channels in the diagram. What follows is a more systematic discussion oriented towards how to deal with these as EDPs. The channels outlined here are not anatomical but "functional," that is, descriptive of how the mind works from the point of view of patients and therapists.

Primary Emotions

Feelings like fear, joy, anger and pain are products of neural activation in our primitive mammalian brain. They are called primary because they are not the result of will or judgment, but arise spontaneously and directly from deep parts of the brain. They are not under our control, but have a strong influence on how we prioritize and choose actions. These emotions seem to be our brain's way of tagging what is best for us. Unless our free will has other ideas, we naturally choose our comfort zone, doing whatever is associated with positive feelings and avoiding actions associated with negative ones.

The most basic, biologically based feelings and associated avoidance patterns, called “unconditioned responses” by Pavlov, represent genetically determined, built-in responses from our brain. An example is pain accompanying an injury. This automatically generated feeling works quite effectively to insure that we use our free will to take good physical care of ourselves.

What makes this simple system, where emotion steers behavior, even more flexible, is our ability to associate other, “neutral” stimuli so they, too, trigger built-in emotional responses. The deer learns to pair the sight of a road, a neutral stimulus, with fear. Pavlov called these “conditioned responses,” where we learn that some arbitrary set of perceptions may soon lead to pain. Now, having been “conditioned,” we react to the neutral stimulus as if it were equivalent to the original injury or source of pain. We now feel the uncomfortable emotion, or the anticipation of it, and take action without having to encounter the danger itself. This adds hugely to the capability of all mammals, including us, to recall, anticipate and avoid potential dangers.

The essence of this simple system is that, while we have free will to choose whatever action we might want, our choices are strongly influenced by primary emotions, positive and negative, associated with each of the available options. Left to our natural instincts, we tend to choose the one that is associated with positive emotions and, even more strongly, the one that helps us avoid negative ones. In other words, we tend to do what is most pleasurable or least uncomfortable, even when this is not, in fact, good for us.

Weight loss is a good example of the challenge of trying to bend our free will in a direction other than where our primary emotions are guiding us. Obesity is not good for us, but for some individuals, the brain seems intent on their eating more than our bodies require. Note that this powerful influence on our choices comes not only from primary emo-

tion, but also involves other channels such as automatic thoughts and impulses, discussed below.

Weight Watchers has done a great deal of research to discover ways to help people go against their primary emotions. They start with a plan that helps keep the difference between following and not following crystal clear. Next they enlist social pressure through group meetings to apply further biological influence. They even use financial incentives. All these are all good tools. Another excellent source of ideas and suggestions is Norcross's book *Changeology*.

In addition to these collections of techniques to change behavior, as with all EDPs, we can also use the emotional approach, bringing the avoided feeling into the room to try to undermine the EDP by resolving the feeling that the behavior is trying to suppress. This means asking ourselves and our therapist what is the function of the behavior. What are the emotional needs driving the behavior. If we can address those directly, then we have accomplished a kind of "end run" or flanking maneuver to cut off the reason why the behavior is there in the first place.

Secondary Emotions

Secondary emotions (some have used the term in other ways, but I think this use of "secondary" is the most valuable one) are those that arise as a result of *judgment* based on some standard. They include *guilt*, *shame* and *pride*. Like the primary emotions, these are also generated by the mind's black box and serve to steer us towards what our mind considers right. But their origin is quite different from primary emotions. The difference is that they are the result of evaluating choices in relation to an internalized standard or template. Jaak Panksepp, who has pioneered the study of mammalian emotions tells us that these are not among the primary emotions that arise from the midbrain in all mammalian species. Rather, these are products of the cerebral cortex or thinking

brain. According to Alan Schore, this function resides specifically in the right prefrontal cortex.

Think for a moment of the power of shame to shape behavior. You will see that this channel of influence has as much power if not more than the primary emotions. Secondary emotions provide a potent positive and negative reward system. We feel pride when we follow our internalized templates of good behavior, and shame or guilt when we go against them. These feelings then put strong pressure on us to choose freely what our internalized standards tell us is good.

In case you haven't guessed, this important system is commonly known as our *conscience* or *superego*. The internalized standards on which it bases its judgments come in four types: *values*, *attitudes*, *ideals* and *prohibitions*. Each of these can serve as a measuring stick for evaluating choices. If you think about the conscience as a control system, it is one specialized in the maintenance of the social fabric. When the system of primary emotions tells us it would feel good to grab a neighbor's lunch, it is our conscience that says, "No, that's a bad idea. You will feel guilt if you do it." In that way, the conscience supports peace and harmony between you and your neighbors.

From the point of view of psychotherapy, what is interesting and remarkable about our conscience is that it, too, is subject to software glitches. We can, and often do, internalize faulty standards. For example, those who have been mistreated or traumatized in early life tend to internalize the same negative attitudes towards the self that were held by the people who hurt them. It is also common to have more than one standard at the same time, including ones that are contradictory. For example a bad attitude about the self may cover up a more positive one laid down before a trauma happened. Therapy will try to bring out the more positive of the two.

An example of the conscience gone awry is anorexia nervosa. In this condition, when therapists succeed in getting the patient to eat normally,

the conscience produces a flood of feelings of shame. Sufferers feel horribly gross and slovenly, even though they have done exactly as recommended. Their conscience has internalized a standard that eating is shameful while starving is something to be proud of.

For excellent reasons, the conscience's standards are very hard to change. In fact, once internalized, they are permanent. Elderly people, for example, who are incontinent for medical reasons, still feel shame based on standards they internalized as very small children. You can see why these standards are lasting because if we were able to bend our standards according to our immediate desires, then our conscience would lose its power to override our primary emotions.

Since even unhealthy standards are permanent, the way we are able to modify the functioning of a faulty conscience is by taking advantage of the layering of our standards. When more than one standard applies, only one seems to be dominant. With considerable work, we can make healthy standards dominant over unhealthy ones. Unfortunately, a negative experience can too easily bring back inappropriate shame or bad feelings about the self derived from the old, unhealthy standard. When this happens, we get a glimpse into the permanence of our internalized standards.

In comparison to animals, the conscience represents a great advance. It makes social standards portable, so that external reinforcement is not a constant requirement for good social functioning. Your dog needs reminding about your standards many times every day, while humans don't. Very important from the point of view of psychotherapy is that internalized standards are not only laid down in early childhood but can be internalized at any time. The Stockholm syndrome, where hostages began to take the side of their captors, is an example of internalization under stress. This ability also has a positive side. It gives us some ability to instill new, healthy standards in therapy, even when negative ones have been present for decades.

The conscience has a particular and important role in the architecture of EDPs. It is frequently the top layer when there are two. The most common multilayer structure is where an original, painful feeling is guarded by a layer of shame or guilt. Shame, for example, becomes the thing we avoid and effectively covers up the original primary feeling. This layering is so effective, that the individual often has no awareness of the original feeling, dreading only the shame or guilt coming from the conscience layer.

A simple example of this arrangement is what happens to people raised under conditions of deprivation. The natural reaction should be anger and complaint, but these have done no good. To the contrary, attempts to complain may have elicited punishment or retaliation. What happens next is that the child, in order to avoid repeated pain (a primary emotion), internalizes a value that being "tough" and needing little is good. From here on, he or she feels pride with self-sufficiency, while any awareness of neediness triggers shame. This is very good as long as the depriving environment is in place. But later, when the individual finds a way out of that situation and encounters a more normally nurturing environment, he or she will have trouble accepting the bounty.

An example is the man who has to return all the birthday gifts because he feels ashamed and unworthy. At the same time, until his values are modified, he will probably have no awareness at all of the original pain he experienced long ago from deprivation. Note that this same structure can affect entire populations or subgroups who are disadvantaged. By Internalizing a value supporting that which can't be changed, members are better able to accept an unjust condition. This may not be healthy for the population, even though it can bring some peace to the individual.

How can we escape from such a multilayer EDP? My best answer is "the kitchen sink." What I mean is that changing values is so hard that we need to use every possible means of influence. The first is education.

It helps to be very clear, at least intellectually, about the reason for having faulty values. Clear knowledge that they are faulty, and that they need to change helps to keep us on the job. Questioning another person's values is a bit tricky for therapists because it tends to stir up feelings of being "corrupted." So therapists need to be clear that the values in question are "foreign bodies" that don't belong there.

Clarity allows patients to "talk back" to their own mind and conscience, reminding themselves where their values are wrong. Even more important than talking back is what I like to call "civil disobedience." This means purposefully acting contrary to unhealthy values. One of the ways we support our values is by acting according to their dictates. By doing the opposite, we send a strong message back to our mind that it is not only right, but actually safe and good to disobey wrongly acquired values.

Automatic Thoughts

As mentioned earlier, our mind is capable of generating thoughts that are indistinguishable from the ones we would like to call our own. But the aim of automatic thoughts is to influence our choices in the same direction as the primary and secondary feelings mentioned above. These spontaneous thoughts work as a kind of backup system, used by the mind in case emotions alone fail to keep our decision making in line with what our mind assumes is best.

To re-use a familiar example, let's consider weight loss. If you decide to eat less than your brain thinks is good, you will feel hungry. This is a primary feeling, telling you to eat. If you succeed in resisting those feelings, then your mind will predictably begin to send you numerous thoughts about food, along with good reasons why you should break your strongest resolution. These are called automatic thoughts.

Of course such thoughts come from the same mind that is capable of creating our best ideas and inventions. When you are struggling with a problem and sleep on it only to find the solution waiting for you in the morning, it is the same problem solving black box that did the work. So, it is perhaps more accurate to think of the mind as a super problem solver, rather than a source of bad influences. Nonetheless, one problem that consistently calls forth our mind's creativity is the need to get as far as possible from troublesome emotions, and this is where the mind has such a prominent role in inventing EDPs and then leaning on our free will so we will chose to implement them.

Psychoanalysis has known about automatic thoughts from the beginning, but calls them "free associations." Alcoholics Anonymous calls them "your disease talking." Cognitive psychology recognizes automatic thoughts as generators of dysfunctional feelings and behavior. These thoughts originate outside of consciousness so it is not possible to know exactly how they are formed. Some have said they are learned, but, to expand on the earlier discussion of "black box" analysis, listening to thoughts reported by people in early recovery from addictions leads me to believe that they are actually made up on the spot to exert maximum influence on behavior. Even a drug dealer could not do better in pointing the addicted person back towards the substance.

The rationalizations of addicts are familiar. "I can handle this," "Just a little bit and no one will notice." Famous last words! Everyone else knows where this thought came from. In fact, my understanding of addiction is that the mind has come to treat the use of a substance as if it were necessary for survival of the species. Once that happens, we are able to see how the mind uses all its tricks to try to influence free will in a direction that is clearly not in the individual's best interest.

The mind's ability to maintain addictive behavior in spite of the most severe consequences gives us one of the best opportunities to observe the operation of the mind's amazing channels of influence. These remarka-

ble mental products are the same ones our mind uses to be sure the human race continues to reproduce and survive. More important, for our purposes, when our mind is set on maintaining an entrenched dysfunctional pattern, even if we resist the emotional tug, automatic thoughts will be right there, promoting the status quo and working against the us and our therapy.

Psychologists have catalogued distorted ways of thinking, such as "catastrophization" and "all-or-none" thinking, that serve to rationalize dysfunctional patterns. Specifically the distortions described are ones that serve quite effectively to argue against therapeutic efforts at behavior change. Psychodynamic or traditional therapists also observe spontaneous thoughts. What they tend to notice are distortions of thinking (they call them defenses, such as denial and projection). The function of these defenses is to fend off awareness of uncomfortable mental contents.

Why are these two descriptions of automatic thoughts different? Both observations make sense, but show the mind working on slightly different problems. Behaviorists put the emphasis on changing behavior, so patients come up with reasons not to change behavior. Traditional therapists urge their patients to face uncomfortable truths and that is precisely what their patients' minds work to avoid. In both cases, the mind is adept at resisting just those changes that are the goals of the particular therapy. In both types of therapy, the mind uses both emotions and automatic thoughts to steer you, the patient, in the wrong direction, away from change.

How can you enhance the effectiveness of your therapy in dealing with automatic thoughts? The first goal is to recognize them for what they are. Here is where we tend to have blind spots, all the more because our automatic thoughts seem so well rationalized and plausible. As stated above, they don't come with anything to label them as different from other, healthy products of our problem-solving mind.

How can you recognize an automatic thought? The two tests that help the most are to ask where the thought leads and to check it out with others. Simply repeating a thought out loud to another person will allow us to hear it from an outside point of view, and we may immediately recognize where it comes from. When your friend says, "You what?" that is a also a good sign that your automatic thought should not be followed.

Talking back to your own mind's thoughts is helpful, as is being sure not to act on them. In Chapter 8 I will frame this differently. I will suggest that you should think of these thoughts as coming from a child who is terrified and tugging on you towards what the child thinks is safety. With compassion and love, I will suggest that you take the child by the hand but firmly follow adult wisdom on what actions to take.

Impulses

One final type of influence is the impulse. An alcoholic in recovery may pass in front of a liquor store with no special desire to drink, and suddenly go into the store. A purchase is made before consciousness and free will have even a chance to evaluate the wisdom of what just happened. The alcoholic will honestly report that a sudden impulse caught him or her by surprise. Impulses are often non-verbal. They consist of urges to take a particular action. What tells me, as a therapist, that this is actually another component of our mind's repertoire of control techniques is that impulses predictably lead us in the same directions as our automatic thoughts.

Now think of what happens when we resist an impulse. We feel a distinct form of discomfort. Interestingly this is a negative feeling that has no name, at least in English. Nonetheless, whenever we fail to follow our impulses, we feel it, a discomfort that is hard to describe but also hard to resist. At those times when we are able to reflect on an impulse, we experience anticipatory feelings saying that it would be much more

comfortable to go ahead and follow the impulse than to resist it. So I believe it is fair to say that impulses have not only content, in the form of an action, but also an emotional push to make sure we follow them.

Much of the training of first responders in uniformed services consists of practicing approved behavior patterns to ensure that they will follow procedure at times when impulsiveness would be dangerous and dysfunctional. Impulses are also closely related to habits, where we systematically omit the step of reflection before acting. When we work to change a habit or an impulse, most of the work is in becoming aware so that we can reflect and, if needed, resist the old and practice a new behavior. Thus, impulses have a similar function to automatic thoughts. They are the mind's backup in case primary or secondary feelings don't sway us. Automatic thoughts work on our free will, while impulses urge us to bypass free will, both promoting the same result.

The Four Channels of Influence

You may be surprised to hear that these four channels constitute the entire range of our mind's ability to steer our free will in directions that it considers good for us. Most of the time these influences are effective and we stay in our comfort zone, diligently following our mind's advice on what is best. Occasionally our own independent ideas come into view. Technically we could say that the mind is a prolific problem solver and it is equally willing to serve the self or the child within. As long as the mind's instinct to avoid difficult feelings is in sync with our own ideas about what is best, then harmony reigns and we remain in our comfort zone.

Then there are times when our adult aims and our mind's ideas of safety and wellbeing are at odds. At such times, when we impose our own will, we feel good about our success. We feel as if we have triumphed against a dysfunctional self and, to make things even better, we

may be rewarded with greater satisfaction in life. It is only when we find ourselves repeatedly losing these battles that we seek psychotherapy. Once again, the job of therapy is to help us do what we have determined to be best when our feelings and dysfunctional patterns are tugging in the opposite direction.

The primary feeling rewards of therapeutic success help to support the gains of treatment and to propel us further in a positive direction. We can also enlist the help of our conscience on the side of health. By adopting and internalizing the value of healing and growth, we can further reinforce our success at countering our EDPs with a secondary feeling of pride.

Seven

Symptoms You Didn't Ask For

In contrast to the avoidant behaviors we choose, symptoms are unwelcome guests. Anxiety, depression, obsessions, dissociation, and bodily symptoms seem to come upon us for no good reason and against our will. They also tend to have significant biological aspects and to run in families. Even so, these symptoms can and do serve, like other EDPs, to avoid difficult feelings. Since they are beyond our direct control, psychological approaches to these must first focus on learning to keep the symptoms from controlling our lives. Next, we can work on diminishing our symptoms by changing the ideas and behaviors that support and amplify them.

Depression

Depression means many things to many people. When a new patient complains of depression, I am aware that the word can represent a number of different conditions. Depression might mean frustration at not having one's way. Or it might mean pain and sadness about a condition that can't be overcome. It might be that the person's biology has gotten out of control and pitched him or her into a state of melancholy with physical symptoms like loss of appetite and inability to remain asleep.

People sometimes confuse depression with grief, which typically produces the same physical symptoms of early waking and loss of appetite. Besides all of these, the most common kind of depression is an expression of self-criticism and a profoundly negative and pessimistic attitude towards the future.

The single discovery that has most influenced my understanding of depression comes from Jaak Panksepp's work on the neurobiology of mammalian emotional systems. Dr. Panksepp, based on 30 years of research, explains that depression is related to a most interesting system in the brain. He calls it the SEEKING system, and capitalizes for emphasis. This network of nerve cells, mainly in the mammalian midbrain, provides the emotional drive to propel us towards any goal our mind might select. When this remarkably flexible system is activated, it acts as a remarkable driving force. Once you understand it, you will identify its profound contribution to your daily ups and downs.

> *"When the SEEKING system is aroused, animals exhibit an intense and enthused curiosity about the world. Rats, for example will move about with a sense of purpose, sniffing vigorously and pausing to investigate interesting nooks and crannies."* (Panksepp, 2014)

For humans, activation of the SEEKING system is intensely pleasurable. We have a sense of excited anticipation with all our senses heightened. We picture the goal as we make our preparations. The feeling peaks as we are about to reach the goal. In some endeavors, like golf, for example, sub-goals keep us reaching. Then, when we finally grasp what we have pursued so avidly, the level of activation quickly fades. We may even feel a letdown. The pleasure is more in the chase, so when the goal is achieved, other emotions must take over.

When we encounter too much discouragement, the SEEKING system shuts down and we experience a feeling of darkness and profound dis-

couragement. This is the feeling of depression. Our mind has decided that whatever is important to us is beyond our reach and hope is lost.

Interestingly, medications can have a powerful influence on this system. Stimulants can over-activate the system, causing psychosis. The "crash" that is associated with coming off a stimulant is due to deactivation of the SEEKING system. Opioid pain medications also boost the system but can change its balance and, through withdrawal, can deactivate it, causing depression. The endorphins produced naturally with strenuous exercise also stimulate the system and give a "runner's high." For this reason, exercise can be a natural antidote to feelings of depression, while discontinuing an existing exercise program can push one further into negative feelings.

The indicator that a shutdown of the SEEKING system and its accompanying depression might serve a self-protective purpose is in the way patients sometimes resist our efforts to help them recover. When the depressed feeling is in reaction to a loss, we can understand the protective reason for clinging to the feeling. After defeat, we naturally want to avoid taking any further risk. We need time to nurse our wounds and heal before summoning up the courage to try life again. People who have had too many defeats, especially in early life may be more cautious than others in accepting the vulnerability associated with hope. While this kind of depression seems very natural, our tendency to hold onto it is once again driven by the need to protect ourselves from negative feeling, namely the pain of yet another defeat. At some point, this avoidance of risk becomes dysfunctional, and begins to represent yet another kind of entrenched dysfunctional pattern, or EDP.

The kind of depression that is associated with self-loathing has another protective purpose. It has long been recognized in psychodynamic thinking, that anger, protectively turned inward as self-hate, eventually results in a feeling of hopelessness, discouragement and depression. Anger is another of Panksepp's basic emotional systems. Intuitively, we

feel that anger demands expression in action. When, for some reason, we can't attack the true object of our anger, we typically direct it elsewhere. Kicking the door is almost as good.

Exploration of depressive self-hatred almost always shows a pattern developed out of early situations where anger at caregivers was blocked and could not be expressed in any direct way. By redirecting the anger towards the self, there are emotional payoffs. First, there is the release gained by hurting someone.

Second, blaming the self can become a reason for hope. How can feeling hopeless be a source of hope? For children, given their limited cognitive abilities, someone must be to blame for every problem. They have no ability to conceive of "one of those things," an unfortunate event that is no one's fault. Furthermore, children don't have a clear sense of whether the culprit is the parent or the self. It is easy for a child to assume that he or she must be to blame for whatever might not be right, especially if the caregiver doesn't seem ready to take responsibility. Furthermore, there are powerful incentives for self-blame. First, anger directed at the parent has already been discouraged or punished. Self-blame avoids repeating those painful experiences. Second, if the fault were identified as the parent's, then there is no hope for the child. Having an inadequate parent is something no small child can accept. On the other hand, self-blame gives hope in that the child might fix the problem by trying "extra hard" to be good or by harsh self-punishment.

Not only is this twist of thinking quite natural, it is, not infrequently, encouraged by caregivers who won't admit responsibility for their own behavior. Even worse are parents who admit failure and apologize without a credible promise of reform. This communicates hopelessness and encourages the child to avoid it by assuming that he or she is to blame.

The degree of confusion about responsibility suggests that this pattern dates back to an early point in cognitive development. At the same time, such thinking requires a grasp of the concept of moral responsibil-

ity. The latter begins around age three, while confusion about who is responsible could still prevail up to, perhaps, age seven. Thus, it appears to me that this pattern, when it appears in adults is likely to have first been laid down around at some point during that early period of development.

If this is you, then let's look at what can be done. I want to start with the adult thought that blame is not a life-and-death matter. No one is perfect and therefore it is not such a terrible thing to go back in history to assign responsibility accurately and correctly. This is not blaming, but clarifying. Even in retrospect, no one is going to be mortally hurt by being identified as accountable, even a beloved caregiver or other important figure. Making the self into a lightning rod for blame doesn't actually help anyone, while blaming the wrong person and the resulting depression do significant damage. So I want to recommend fearless exploration of true causation and responsibility for things that might not have been right. I think of it as taking the self "to trial." The aim is acceptance and forgiveness, not punishment. As a result, no one will really be hurt and someone, namely you, may be saved.

Inappropriate self-hate seems at first to be a symptom or feeling that comes upon us unbidden and entirely outside our control. While this is true, the feeling is heavily reinforced and maintained by automatic thoughts and dysfunctional behaviors that are, at least somewhat, under voluntary control. Depressed people insist on their unworthiness and find rationalizations to support it. These are usually circular. "I am certainly a worthless person because I stay in bed all day." The therapist responds, "But you stay in bed all day because you feel like such a worthless person." Furthermore, self-punishing acts generally reinforce the feeling of being blameworthy. "I am punished, therefore I must be bad." These thoughts and behaviors need to be reviewed in detail and voluntarily relinquished.

Perhaps you can sense some energy in my description. This is because the work takes a good deal of drive and persistence on the part of the therapist. Unreasonable self-blame has a great deal of staying power, and does not melt away easily. As the adult of yourself, any help you can give to yourself and your therapist will make the job easier and will make you more successful.

After some progress, the depressed individual may begin to realize that he or she has some control and even a choice of responding to a new situation with a more realistic assessment of responsibility. As you realize that you are not to blame, anger is very likely to come to the surface. That is good, because only then can it heal. Adult children whose parents are living are likely to want to confront the parent. I recommend that this be done only after the anger has had a chance to heal. Done too soon, the confrontation can represent a child's attempt, at last, to punish the right person. Punishment is a childlike response that rarely does any good. It is rare, but possible, that the parent will be able to respond in a mature way but, just as likely, the result will simply be an ugly scene where the parent uses the same old methods to put the blame back on the adult child.

Before turning to other symptoms, let me return to the varieties of depression mentioned first, before this extensive discussion of the kind based on inappropriate self-blame. Sadness or depression that comes from realizing the hopelessness of a situation is the same as grieving. The answer to this kind of loss is to let the feelings come out in the open in a context of connection where they can heal. It may take time, but will lead to transformation from acute pain to a dull ache.

Another feeling that can be identified as depression is what I call "tears of protest." Sometimes complaints and tears represent a refusal to acknowledge and accept the irreversibility of a loss. Identifying this refusal is the key to healing.

Finally, biologically based melancholy that might have gone too far to be reversed with words, may require drug treatment or other physically-based approaches before talk can have an effect.

Whatever type of depression it might be, self-harm and thoughts of suicide are serious matters, not to be ignored. These are urgent reasons for seeking professional help.

Grief

Having explored the depths of depression, grief is so much more understandable and straightforward. Grieving is a natural and healthy reaction to loss of someone or something we have been attached to, so we can't really call it "dysfunctional." There are three good reasons for including it here. First, if you ask someone who is grieving, or you, yourself, have had the experience, you will probably agree that it is one of the most painful states that humans can endure. Second, sometimes it can take on a life of its own, becoming "pathological grief." But most important, the process of grieving is as important to therapy as the healing of fear reactions.

The reason grieving is so important is that a great number of our EDPs were originally developed to avoid feelings of grief. Children have little capacity for letting go of wishes and needs that feel vital to their survival. So when something is missing in childhood such as love or attention or competent parenting, the mind finds ways to put those unfulfilled needs on ice, waiting for the day when they can be fulfilled.

The child within waits diligently, or may even substitute some hoped for future achievement for what he or she didn't have. Often it is the therapist who may be designated to fulfill the need. While therapists can and do give understanding and compassion, they can't adequately fill the empty places left from early life. As this realization comes into the therapy, then we are faced with the dreaded work of grief. There is one more

factor that makes grieving for deferred losses significantly more difficult. Earlier we saw that painful feelings from the past, when they are stored away in the mind, retain the level of dread that they presented at the time they were buried. In the same way, the mind's avoidance of deferred grieving shows that buried feelings of loss continue to be treated as life threatening, just as they must have been long ago. For this reason, adult patients resist letting go of their deferred wishes, unrealistic or not, as if they were holding onto life itself.

Grief applies not only to human relationships. Anything we have been attached to, whether a person, an animal, a wish, a principle, or a belief, can be felt as a terrible loss that will continue to cause pain until the work of grieving transforms the loss into a dull ache. When losses have been kept "on ice," and they finally come to the surface, it is as if they have suddenly hit us for the first time. The grief is acute, even though the loss may have happened long ago. As the awareness of loss comes to conscious awareness, the affect of grief immediately takes hold. So it is that grieving for losses that have been deferred is just as natural and just as immediate and necessary as grieving for losses that take place in the present.

The work of grief appears to be the same as the healing of fear and other affects. The difference is that it takes place over time and in waves. At first, we are consumed with grief. The SEEKING system shuts down completely and we see no future, no hope, only blackness. At this point, any words of encouragement seem hollow and offensive, a contradiction of the reality that engulfs us. We focus on multiple aspects and details of the loss. Why it happened, whose fault was it, what will be the consequences, what are the implications for the future, how life would have been different if it had not happened. At first, we could not imagine thinking of anything but the loss, then there begin to be breaks. We may occasionally notice something beyond our preoccupation.

As the experience begins to take up less than 100% of our emotional life, we can begin to observe the healing process. With each wave of affect, especially in a context of understanding and empathic connection, small bits of healing take place. It takes many waves of pain and many small portions of healing for progress to be felt. This healing applies to each facet of the loss, so grieving for one part doesn't take care of the others. What is grieved may be intangible. For example, one aspect that makes the loss of a child so terrible is the life that person would have had in the future. The healing process that slowly makes a difference is the same as the healing of other feelings like pain and anger. It is feeling the affect in a context of empathic connection that gradually disassociates the pain from the fact of loss.

It isn't quite clear whether the slowness of the process is because of some inherent quality or if it is because we are only able to activate and heal a small chunk at a time. As the process goes on, the waves are less intense and farther apart. Duties or other activities begin to engage some of our emotion and, in time, predictably, we will be ready to see a future where there was none before.

The process can't be hurried, even when everyone else is ready for it to be done. This time element needs to be respected. When there is no substitute for what has been lost, it is not forgotten. What remains is a dull ache, an emptiness. One man could not bear the loss of his beloved dog. After a few months, in order to soften the pain, he adopted a new dog. It helped a little, but this was a different relationship and his grief for his old "pooch" continued to take its course.

At times, substitution is possible. The easiest way to let go of a girlfriend or boyfriend relationship that has not worked out is to find a better one. In this case, the grieving is probably not so much for the person as the image or ideal that he or she represented. The new love simply steps into the picture, and there is no loss to grieve.

There is such a thing as grief becoming a way of avoiding some other feeling, an EDP. That is what underlies "pathological grief." The indicator that this is happening is that the progression of the grieving process becomes stalled. We have to be careful that the impatience of those who are close to the grieving person doesn't result in a wrong judgment that the process is not moving when it is simply taking the time it must.

If grief has, indeed, become dysfunctional, an EDP, then the way to approach it is the same as for depression, to clarify what feelings are being distanced and to approach either the feeling, or to approach potentially voluntary behaviors on the part of the grieving person that are serving to keep the pain and distress going. One example would be grief that must be maintained in order to avoid guilt or anger. If the grieving person has buried a feeling of guilt or responsibility that can't be faced or dreaded anger at another who is seen as responsible, that might be a reason not to resolve the grief. In that case, the guilt or anger will have to be brought to the surface and faced.

Anxiety and Panic

Fear and panic correspond to two more of Panksepp's basic mammalian emotional systems. The fear system responds to danger. The panic system is specialized in responding to aloneness or the threat of loss of attachment. In humans, there seems to be enough overlap in the things that trigger the two reactions that I won't separate them. On the other hand, the two experiences do differ in that anxiety tends to be constant, while panic happens in attacks that come on without warning and last minutes to hours. Panic attacks also correspond to an outpouring of adrenalin, causing symptoms like a pounding heart and fear of death.

When we are not in immediate danger of external harm, we experience both symptoms as fear or anxiety. Neurologically anxiety implies

activation of these emotional systems for no rational or realistic purpose. Once again, we can explore what is behind anxiety by the three methods mentioned in Chapter 5: spontaneous thoughts, resonance, and observation of the results of work based on our hypothesis. These three threads typically lead to a sense that the mind has identified a specific circumstance as dangerous and is sending out alarm signals. Sounds like an EDP!

As with depression, the feeling of anxiety is only the beginning. Fear is a primary emotion, and can be thought of as the product of one of the four channels that aim to influence our behavior. The mind is saying "watch out!" Next, come efforts to ward off the anxiety. When the source of fear is not clear, then we struggle to find what to run from and where to run. Our mind may supply trivial or unreasonable reasons for fear, or we may take note of the circumstances present at the time the anxiety came upon us and seek to avoid those. In the end avoidance of anxiety becomes a preoccupation and distraction that leads us ever farther from whatever might have been the original source of fear.

The worst thing that can happen is for us is to succeed in making the anxiety go away. Not uncommonly, actions we try are successful in taking away the anxiety, but only temporarily. This encourages us to do more of the same. In the case of panic, it is dread of being surprised by a sudden attack that becomes a preoccupation. Anxiety can easily come to dominate our lives and activities, robbing us of any semblance of normality.

Sadly, doctors may apply similar, superficial remedies. They are trained to relieve suffering, and benzodiazepine sedative medications like Xanax and Klonopin do a good job of suppressing anxiety. They work in a way identical to alcohol, and soon we may find ourselves depending on these medications to fight feelings of anxiety. The problem is that the dose must be increased, with eventual physical dependence. Meanwhile, we learn nothing about coping with anxiety or about dealing

with it by understanding what our mind is worried about. The side effect is that we are chronically in a state of low-level drug-induced intoxication. Our thinking is dulled and we become less safe on the highway. To make matters worse, the main withdrawal effect of decreasing the dose of sedative medication is none other than *anxiety*.

It is true that some people are genetically more anxious than others and that medications can work to a degree. On the other hand, many individuals spend years under medication, deprived of any chance at healing or growing. Why is that? Recall that healing of emotions requires that they be activated, not suppressed. Treatment that suppresses feeling blocks both extinction and reconsolidation.

When medication fails, the medical system has another remedy, disability benefits. These may be lifesaving, but the side effects of giving up functioning in the adult world can be devastating in the course of a life. Such a decision needs to be taken very thoughtfully and with full awareness of possible consequences.

If you are afflicted with anxiety for no clear reason, then what can you do? Cognitive-behavioral therapy suggests first learning not to allow the feeling to govern your life. Realizing intellectually that you are not really in danger is a beginning. Understanding that your pounding heart and feelings of impending doom are normal consequences of an internal, non-harmful dose of adrenalin helps a bit more. Mindfulness is the latest way to fight back. In "surfing the feeling," you remind yourself that this is no more than a reaction of the moment, a signal that your mind has mistakenly set off an alarm that will soon fade away.

The next part of treatment is to address the thoughts and behaviors that amplify the feeling. Curbing impulses to avoid the anxiety will, of course, temporarily increase the anxiety. When this happens, techniques for healing and managing the feeling are appropriate. As some calming sets in, then it may be time to work again on curbing your impulses and talking back to your irrational thoughts.

Joan Baez, a famous singer, now in semi-retirement, revealed to a TV interviewer that she had terrible stage fright when she was in her prime. She reported that she would sometimes interrupt a concert and go back stage to pull herself together. The interviewer then asked if she still experienced the same thing. She thought for a moment and replied, "No." Apparently her intense anxiety had gradually abated. I tell the story, because that has been my experience as well. I have seen intense anxiety gradually resolve over years. This is not to discourage the reader from working on anxiety problems, but to reassure you that expecting results too quickly may lead to unnecessary discouragement and that there is hope for long-run gains.

Anxiety typically represents a two-layer EDP structure. The surface layer, the one that we tackle first, is focused on avoidance of anxiety itself. Under that, is the original EDP, consisting of a circumstance associated in the mind with danger, leading to production of anxiety as a warning and impetus for self-protection. CBT focuses on the surface layer, taking a behavioral approach. Traditional talk therapy tends to look more at the layer underneath, the one where the mind originally sensed some non-obvious danger and tried to get us to avoid it. One takes the behavioral approach and the other, the emotional one.

Growing up is hard. We all know that, and one of the most common sources of anxiety is the childhood experience of having to be grown up when we don't feel we have needed capabilities or support. Every step towards greater maturity naturally asks for an extra measure of parental support. When the child steps on the school bus for the first time, a sensitive mother will naturally give encouragement and understanding without backing off in the expectation that the child will step onto the bus. Then there is an exchange of regard, where the child asks if it will be OK, and Mom's facial expression says, "Yes, and I'll be here when you return."

If, for some reason, this kind of transaction did not become established and comfortable, it might result in a piece of unfinished business which could be re-awakened at a point in the future by an imbalance between the demands of life and the level of support available. Imagine Alex, who has just gotten a desirable promotion, and soon after, experiences his first panic attack. He wonders why, when everything is going so well, he should have a problem. But the story doesn't stop there. If he becomes crippled by anxiety and has to step down from the new position, then his mind has accomplished exactly what it set out to do, to limit the level of performance expectation to match the level of support.

It is because of serious consequences like this, that the goal of learning to cope with anxiety and practicing those skills should be the first line of attack whenever possible.

Obsessions and Compulsions

Obsessions and compulsions also have an important biological basis. They have been found to be related to the deep mammalian brain's necessary and important error detection system. When this brain system is over-activated from neurological damage or for any other reason, it sends excessive signals to check for errors and to worry about having missed something. The result is a very strong feeling of worry or of having to make sure that some action is done properly.

On the other hand, the specific thoughts and acts that pop into consciousness may have to do with unfinished business from the past. Even though the impetus to check is largely biological, the end result, at least for compulsive actions, is an EDP, that is, a pattern of avoidance to distance from anxiety. Serotonin enhancing antidepressant medications can often relieve the sense of worry and the biological drive for compulsive behaviors. However, and perhaps more interestingly, simply curbing the behavior leads to similar chemical changes in the brain and eventual re-

lief of the compulsion. CBT therapy for compulsive rituals focuses on learning to tolerate the anxiety that results from a decision not to follow the impulse to perform the ritual. Changing the behavior then reverberates through the brain resulting in an improved chemical balance.

Letting go of compulsive behaviors is hard to do, and is a place where a very strong therapy relationship is an important part of successful therapy.

Dissociation

When emotions attached to an experience become more than the individual can handle, some people have the ability to wall off parts of experience from conscious awareness. This is the mind's natural circuit breaker. The most common examples can be seen when disaster strikes. Television reports show people with a blank look, going through the motions of doing what they must, but seemingly with little emotion. They are probably in a dissociative state where they have awareness and knowledge of what has happened, but their feelings have been cut off. This kind of cut-off is a typical part of PTSD (Post Traumatic Stress Disorder), where painful events, or aspects of them, are kept out of consciousness, but intrude in the form of flashbacks. When it is more extreme, dissociation can cut off whole memories or even parts of the self.

Dissociation is similar to what happens in hypnosis. It works to protect us from overload. This reaction is an automatic, built-in capacity that is more developed in some people than others. Part of this is genetic, but people who have been traumatized early in life tend to acquire a greater ability to dissociate.

Sometimes dissociation becomes a problem, an EDP, when it would be healthier to face the painful or once-overwhelming feeling. The mind still thinks it must keep that feeling at a distance. Helping patients undo

dissociative barriers is challenging because the mechanism is almost entirely involuntary and automatic.

Usually there are periodic small bits of awareness of memory or feeling that can lead, in a very safe and supportive environment, to bringing the dissociated contents back to consciousness. Each thread of feeling or recall, treated with respect and care, can lead to more awareness of what had been buried. As feelings are recovered, they are activated and become accessible to processing and healing within the context of the safe and empathic relationship as is now familiar.

Focusing on these must not be done in a way that is coercive or fear inducing, as this can lead to a negative reconsolidation of the experience, otherwise known as retraumatization. EMDR can be helpful in creating an atmosphere of safety and control of the intensity of feeling. Hypnosis can sometimes be used effectively to bridge between the present and dissociated material. There is a rich literature on specific approaches to these problems.

Another group of dissociative problems involve feelings of "derealization" or "depersonalization," where it is the feeling of familiarity that is cut off or dissociated. The individual feels that the environment is unreal or no longer experiences the self as familiar. These can be very troubling symptoms and are not easily treated. With limited experience, my observation is that the intense focus on one's own sensations is very similar to self-hypnosis and can be expected to create a vicious cycle in which ever greater focus on inner sensations leads to more intensely abnormal sensations. Medications have yielded equivocal results. The best answer to this condition, I believe, is trying to focus on things other than the symptom, along with mindful acceptance that a degree of dissociation exists and will take a course of its own.

Somatization

Physical symptoms such as blindness, pain and paralysis can occur on a psychological basis. These "conversion" symptoms, when investigated, turn out to have no physical basis. These were the kinds of symptoms commonly referred to as "hysteria" in the nineteenth century. They were the symptoms that brought Anna O. to see Dr. Breuer and to invent "the talking cure" in which she worked on traumatic experiences and her feelings about them. As she did so, her symptoms resolved. The way to approach these, entirely involuntary symptoms is by exploring the feelings and experiences that have led to them. Here automatic thoughts, in this case better thought of as free associations, may lead to uncovering the circumstances and associated negative emotions that are driving symptom formation. The cut-off between feelings and symptoms may, as in Anna's case, be due to dissociation. The same therapeutic principles that help with dissociation are appropriate for somatic symptoms on a purely psychological basis.

Peter Levine has pioneered an additional avenue for understanding and treating somatic symptoms. According to his excellent work, experiences can be "frozen" in the body in the moment of a trauma. By carefully unpacking the experience in a safe and respectful environment, elements of the experience can, for the first time, be metabolized in such a way that healing ensues and the symptom vanishes. He has used this technique for numbers of war veterans and other victims of trauma with dramatic results.

Eight

Befriending the Child Within

In this chapter, I want to share with you, the reader, a deeper and more powerful way to help out with your own therapy. Especially when personal problems are particularly debilitating, I have increasingly come to see one approach as embodying just the right attitudes and stance. This approach is to see dysfunctional patterns as belonging to the child of yourself, trying to protect you. This leads to dealing with that young person with the care and compassion that you would want to show towards any real child. This method may seem silly, but it is not. It is accurate, effective and proper.

Shame

What made me realize I needed to share this point of view was the recurring theme of how patients often treat their immature patterns with anger and self-criticism rather than with understanding and compassion. Even when they are correct in seeing dysfunction, a negative attitude towards that part of the self is a serious impediment to healing. When we turn negativity on ourselves, it effectively stops progress and supports the old status quo.

The best answer I have found to this problem is to explain that the self being criticized is actually a very young part. It is much easier to feel compassion towards an innocent child than a "stupid" and self-destructive adult. What's more, identifying the dysfunctional pattern as coming from a child is not a trick, it is perfectly accurate. Here is why.

When children run into adverse conditions, somehow they know that their first priority is to protect their future. Instead of developing in negative ways, they are more likely simply to freeze their development at its current level and plan how someday to find better conditions.

Traditionally in psychodynamic language, this was called "fixation." In therapy the patient would "regress" to an earlier stage of development. The trouble with that way of thinking and speaking is that no one would want to be guilty of regressing. It is far too shameful. Any self-respecting patient will go to considerable lengths to deny such a thing. That denial, of course, blocks further progress.

Thinking of oneself as having different parts gives a completely different slant on the problem. Looking upon a separate, young part of the self takes away the stigma and brings out the caretaker in all of us. We want to help the child as a parent and not to be a harsh critic.

Is the Inner Child Real?

How can I argue that this is literally true? In the course of our lives, we shift around much more than we generally realize. Think of yourself driving away in a new car or going to a party in your new dress. Then think of yourself on the first day at a job, or under criticism. Perhaps you remember as a young adult, having been away from home for some time, and returning to the parent's home. Within hours a once-confident young adult begins to feel like a child again, and all the old patterns of interaction return. Technically we call these "ego states," but in effect, they are

significant variations of our personality. Because we are accustomed to thinking of ourselves as one person, we tend to ignore the differences.

In intensive therapy, the phenomenon is more obvious as time goes on. We begin to experience feelings and reactions that are distinctly not adult. Perhaps we fantasize about meeting the therapist outside the office. Not far behind are wishes or feelings that don't seem appropriate to the professional relationship. This person who feels young and has young thoughts and wishes probably disappears as soon as we step out of the office into the world. We may perform perfectly well outside, but in the safety of the therapy room, an old, familiar, but suppressed part of the self is able, at last, to come out.

I am not alone in thinking this way. John Bradshaw first popularized the idea and more recently Richard Schwartz has given it more systematic treatment with the Inner Family Systems Model of treatment. My own comfort with this way of thinking started with treatment of people with dissociative identity disorder, or multiple personality, in which different parts of the self are separated by dissociative barriers.

One day, I answered the telephone in my office in my usual tone of voice. My dissociative patient exclaimed, "Oh, It's your secretary!" She meant that she had reached a different part of myself than the one she was accustomed to in sessions. I realized that the me she was speaking to was, indeed, markedly different. The experience got me to thinking how much we all shift within ourselves. The fact that we go by one name helps us maintain a sense of sameness, but the truth is that we are more variable than we usually think.

So, yes, it is accurate, when we exhibit young thoughts or patterns of perception and behavior, to say that a younger part of our self has come to the fore. What makes this a bit more complicated is that from within our consciousness, it is hard to realize whether we are thinking and speaking as a child or adult. By paying attention, we can learn to tell the difference, and, more important, make friends with our younger parts.

Here is an example of how childlike thinking can be expressed in a way that is hard, at first, to distinguish from that of an adult. One patient in her sixties complained to me that, for the length of time she had been in therapy, she should be well by now. That sounded like an adult statement, but the factor that was slowing her progress was her childlike expectation that I, the adult, should simply do an unspecified something that would magically heal her without work on her part. In childhood terms this made perfect sense. If her mother had actually done her job adequately, the problems would not have developed in the first place. So she continued to wait for me, as parent substitute, to do my part and make her better. At first she was critical of the childlike aspects of herself, then gradually she came to treat them with more warmth. Only as she gradually came to see and accept the childlike qualities of this aspect of herself was she able heal her feelings about the unfairness of having to raise herself. That emotional work was something I could not do for her.

Transference

The traditional language for this same phenomenon is *transference*. The original concept was that the patient mistook the therapist for someone from the past. The natural goal of therapy was to correct the error. To me, this is right in fact but wrong in tone. The terminology tends to paint the phenomenon as a distortion rather than the natural emergence of a part of us that needs to be seen and heard from. The young part of us has been waiting patiently a long time for a chance to fix conditions that blocked healthy development long ago.

The most powerful way to recognize the signature of the child within is to realize that children have an entirely different way of solving problems, even of seeing the world. To put it simply, children solve problems by influencing a grown-up to solve them, rather than by taking action

directly. The child has only a vague and somewhat magical idea of how the adult is going to solve the problem, but a much more clear idea of how to influence the adult. In contrast, adults solve problems by tackling them directly, assessing precisely what is needed and doing that. Let's look at an example.

A man had seen a therapist for a number of years but made little or no progress in dealing with his feelings of being a fraud. He recognized that he felt perpetually like a boy pretending to be a man. Over the years they spent together, he diligently attended sessions and, as instructed, said just what was on his mind. Often he wished that his therapist would give him more concrete help in moving towards manhood. The therapist told him that that was not part of the technique and, as an intelligent man, he should be able to find his own way. The patient would bring the issue up from time to time, but knew how the conversation would go. He continued to feel ill equipped to find his way, and made little progress.

As a child, he had very little effective parenting. His father left when he was four and his stepfather, who arrived three years later, was better at admonition than nurturing. His relationship with the therapist exemplified a classic transference. He related to the therapist as a father figure, hoping he might receive the fathering he had never had. The therapist followed a blank screen technique, which is designed especially to bring out transference, and it did. However, instead of understanding the patient's wish and helping him put it into perspective, as called for by good technique, the therapist repeated the childhood trauma. Like the parents, his answer was simply "No!"

What his patient really needed was to accept that his parenting had been inadequate and, when emotionally ready, to take charge of his life. Coming to this kind of acceptance is never easy, but would have been achievable if the therapist had really been understanding of the childlike needs that felt completely real to the patient.

Sadly this type of therapeutic error is not so uncommon. It is particularly so because transference doesn't look like transference, it looks and feels like life. The patient wanted help doing what he didn't feel he knew how to do. This sounded adult but wasn't. The adult was intelligent, resourceful and good at problem solving, but the child felt lost and in need of help and support. The therapist wasn't wrong in seeing that he couldn't really teach this adult patient to be a man. Both of them missed the fact that there was a child in the room who was still looking for what had been missing years earlier and trying to solve the problem in the way children do: motivate the therapist to do what was needed.

The subtle tipoff that there was a child in the room was that a grown man was asking for help with knowledge that is commonly available to grown-ups. An adult solution to the problem would be to talk with his wife and friends to fill in any gaps in his understanding of normal adult ways. This might be a bit embarrassing, but once he got over the shame, his wife and good friends would be happy to help out, just as they might with a foreigner newly arrived in a strange country.

So the fact that he was waiting for help to arrive when it was all around him, was the clue that this was a child waiting to have his problem solved by the parental figure in his life, namely the therapist. He was trying to influence the therapist to address the problem, rather than setting about solving it directly. Besides his not turning to his wife and friends, there was another aspect to his behavior that indicated the presence of a child. Adult problem solving would start with a detailed and concrete analysis of the problem. What, exactly was it about adulthood that he didn't understand? Instead, in a childlike way, he had a simple, global notion of adulthood and knew that it was different from his day-to-day experience, but didn't try to understand more than that. Why should he? Such a thing would be beyond the ability of a child and better left to the parent to understand and guide him.

Adult Temper Tantrums

Now that we are beginning to have a sense of what it looks like to have a child cohabitating with an adult, a phenomenon that is more common that one might think is the early childhood temper tantrum transposed into adult terms. The clues here, are inappropriate anger and failure to access effective, adult solutions to a problem.

Another patient was chronically angry. She would find fault with her employers, her parents, her boyfriends and her therapist. She had worked very hard in therapy to let go of dysfunctional patterns of behavior, yet she still didn't have the relationship and career that she wanted. After a period of being particularly good in curbing self-destructive symptoms, she began a romantic relationship, but after a few weeks was dropped with no explanation. She went immediately into a rampage of self-destruction and wondered why she couldn't seem to stop. This was a temper tantrum. She had done her part, being a very good girl, but the man, like her father, did not respond. Her raging was that of a child who has run out of ways to solve the life and death problem of finding love.

The wrong way to deal with a childhood temper tantrum is to shut the child in its room to smash toys, crayon the walls and make a bad situation worse. Something similar is what often happens when adults have the equivalent of a temper tantrum. They are left to themselves to rage and destroy.

A better way for children is to scoop the child up, not allowing her to do any damage to self or others, and talking with a compassionate voice till the tantrum subsides and tears come. The tears mean the child is over the rage and ready to accept warmth and comforting. In doing so, the parent is creating a context of safety and empathy to heal the emotions and allow the child to learn that anger is OK, but that destructiveness is not. The equivalent for an adult in a tantrum is to do as good a job as possible of preventing harm including, for example, using hospitaliza-

tion or extraordinary outside supports, and to keep up soothing talk and listening till the raging child inside comes to the end of his or her anger, and is able to accept warmth and support again.

Compassion

In each case, the luxury that the child never had was someone who understood and was not critical of the child's perfectly understandable feelings and behavior. Tara Brach is a proponent of Buddhist mediation, but also a leader in recognizing the place of compassion in fighting the shame that binds so many who have experienced deprivation. This is the key to healing, since it addresses the usual two-layer, combination EDP. The deeper layer of leftover pain is disguised by a negative attitude towards the self, now part of the conscience, then self-harm covers up the rage with action. Compassion is what can dissolve this ugly bandage.

Even with loving, giving parents, there are many problems that can't be solved. When there is no solution, no way to fill an emptiness, what good parenting does is to use understanding and compassion to help the child accept life as it is. This is the same emotional healing that is central to psychotherapy. But children often don't know about this kind of healing, especially if they come from a dysfunctional family. All they know about is having the parent fix the problem. When, in childhood, there is no fix, then the needy part of the self goes into hiding, waiting for the day when a grown-up will come along who knows how to fix things. Of course the therapist is that grown-up.

This situation can create a knotty conundrum for both patient and therapist. It is totally understandable and even normal for the childlike part of the adult patient to look to the therapist to solve the problem. Of course the adult patient and the therapist have understood and agreed that the patient will have to do the hard work and the therapist will only be a facilitator. When the therapist explains this, the patient nods, but the

child within experiences disappointment and anger. That's exactly what the parents did; they refused to help.

While the adult accepts the differences between therapy and parenting, the child goes underground and waits for the right conditions and an opportunity to motivate the therapist to do his or her "job." There may be a prolonged period of very gradually more obvious demands and anger on the part of the child, still couched in "reasonable" adult terms. At this point, no solution works. If the therapist attempts to fill the patient's emptiness, this will generate hope at first, then anger that the solution isn't the right one or doesn't go far enough. After all, adults can never really fill the shoes that the parent should have. If, as in the example of the man who felt like a boy, the therapist declines to help, then the patient secretly feels unfairly left on his own. Eventually feelings intensify and hopefully the issue spills out into the conversation where it belongs. This is where it is most important that the therapist's training kicks in and he or she recognizes a child in the room.

At this point, compassion is really critical. The patient is feeling angry and embarrassed for having feelings one shouldn't have. A therapist who is compassionate about the patient's disappointment, but also honest and clear that he or she can't really fix the problem, will eventually be able to move the conversation to acceptance of the shortfall that was experienced years ago. This process may take a long time and a lot of energy. The disappointment is very real and very upsetting. And no one arrives at acceptance until they are quite sure that the original problem truly can not be fixed by the therapist or anyone else.

Paradoxically, then, what the therapist ultimately gives is not the solution to the child's problem, but the compassion that was missing long ago. In this way, while being unable to give the patient what he thought he needed, the therapist actually does give the patient what he really needed, the empathy and compassion that allow old wounds to heal.

In addition, the therapist's understanding and warmth allow the patient to find compassion for himself. At long last, he can learn that even if he has unreasonable needs and wishes, even if he is angry, he is still lovable.

Nine

A Glimpse Behind the Curtain

In starting to write this chapter, I wanted to say that therapists are really just ordinary people. Then I remembered attending a conference in San Antonio, Texas on the weekend of a big football game. Watching passers by on the River Walk, there was little doubt which were the therapists and which were the football fans. The men, at least, were the serious, intellectual looking ones in blue blazers and beige pants. I guess we're not entirely ordinary.

Given the amount of training needed and the nature of the work, your therapist is probably someone who was seriously drawn to the profession by some personal satisfaction beyond making a living. This could be good news or not so good. Therapists may be attracted by the hope of finding the solution to their own problems. I have known a few who were motivated by the need for power and control over others. But the majority are people who like to help and have recognized in themselves some talent at understanding how the world looks through the eyes and heart of another.

But the person you see in the office is actually an odd combination. Yes, this is a person who has feelings, aspirations and worries like all of us. Yet he or she has also hopefully understood that what you need and expect is someone who has parked his or her own concerns outside the

door and entered the room for the sole purpose of helping you. A therapist, in order to be helpful, needs to put your needs first. This means that the therapist's financial needs must be taken care of by fees received (or occasionally experience), while his or her emotional needs should be sustained by outside relationships.

Is it OK for therapists to enjoy their work? Yes, of course, but not at your expense. This is a lot to ask of a human being. In actual practice, our humanness does tend to intrude from time to time. Occasionally, we may have a bad day that affects our work. We might be distracted or less warm. We might be subject to a reaction that has to do with some issue we have not fully resolved. These things are not supposed to happen and if they do, we owe you an apology as well as a chance to explore your reaction. On the other hand, sometimes when our personal feelings show through, patients welcome the reminder that we are made of flesh and blood like you.

The result is a unique relationship that is closer to child-parent than anything else in the adult world. Where else is there a relationship where you can point out the person's flaws, be angry, and say pretty much anything, while expecting the other person to focus, not on their feelings but on yours? Yes, the relationship with your therapist may have a resemblance to a parent-child relationship, but neither is it the same. Parents are ultimately responsible for their child's life and wellbeing. Therapists are only responsible for providing careful, professional treatment according to community standards. Besides accountability, what this means is that when you walk out of the office, as an adult, you are ultimately in charge of your own happiness.

Does this one-sidedness mean that it is OK to abuse a therapist? No. Hurting a therapist in order to feel better is a form of "acting out." (see Chapter 5) It doesn't help you and hurts the therapist, so it's not OK.

What All Therapists Do

Regardless of the school or brand of psychotherapy, therapists spend their individual therapy time and energy on the same five activities. This is one more reason why the isolated silos of traditional therapeutic schools need to give way to broader understanding and collaboration. Here is what therapists do:

1. Creating and maintaining a safe and attuned relational context: A safe and empathically attuned therapeutic relationship is not only the key to patients' motivation to be vulnerable and try new patterns, but also provides a disconfirming context to erase those associations between triggering circumstances and dreaded affects. Note that the relationship is the one, universal instrument that facilitates facing and healing difficult feelings. Not all therapies recognize this function but that doesn't stop healing from taking place anyway. Furthermore, all therapies pay attention to the relationship.

2. Helping to bring dreaded feelings into consciousness: We have already seen that activating feelings is a necessary condition for detoxifying or healing them. Making feelings palpable is the primary focus of experiential therapies and more of a side effect of cognitive therapies. Activation of feelings is the real benefit of challenging or interpreting defenses in psychodynamic therapies. All therapies end up bringing feelings "into the room," where they can heal. Along with the relationship, this, too, is a critical part of facing and healing uncomfortable feelings.

3. Challenging and inviting change of dysfunctional patterns of thought, values and behavior: Replacing dysfunctional patterns with healthy ones is the second of the two basic tasks of psychotherapy. Modifying avoidance patterns accomplishes the dual aims of improving

functioning and uncovering feelings that still need to be healed. Techniques include motivation, education, understanding, self-talk, and finding the courage to make voluntary changes in behavior.

4. Building together a narrative framework to support change: Narrative, or story making, is part of every therapy. Both patients and psychotherapists instinctively embrace the task of stringing our life events into some kind of coherent tale. Why this is important to us is not fully clear. It is fundamental in disconfirming erroneous beliefs like the one that perfection will earn love. It also promotes mindfulness, giving a sense of perspective on our feelings and our life. It gives us the satisfaction of having an explanation of how we got where we are. And finally, it probably recruits our SEEKING system, motivating us to create for ourselves a happy ending.

5. Seeking to understand what is observed: Therapists have always needed to develop a working hypothesis to understand what they observe and to know what to do next. This becomes the basis of our ability to tailor therapeutic interventions as the process unfolds. Therapists and patients also need to treat their hypothesis or formulation with appropriate skepticism, being ready at any time to seek a more accurate one.

I hope, now it is clear that these five activities each relate directly to the two tasks required to resolve each EDP. On the most basic level, all the different brands of psychotherapy are focused on those tasks: detoxifying painful feelings and changing dysfunctional patterns of thought, values and behavior.

If in Doubt

Therapists are professionals. Seasoned ones have seen and experienced many emotionally charged situations, and have hopefully experienced their own personal therapy. You should not be reluctant to confront or question a therapist. They should be able to handle your input in a professional way. Even if you are critical, they should be able to stay with you and help you sort out what part of your reaction is more about you and possibly your past, and what part belongs to them. A good therapist should be ready to help you as a partner in this very important work.

If you find yourself with critical thoughts about your therapist, you *must* speak up. This is a big opportunity for learning something important about yourself and/or about your therapist. Angry or critical feelings that might have started out aimed at a parent or caregiver can become focused on a therapist. No matter what the source of feeling, you will home in on something that seems worthy of criticism and you will also have a private interpretation of your therapist's motivations. This kind of transference is easier to sort out when the therapist hasn't really done anything out of line. Then you will be able to see more clearly that it is really about you. On the other hand, if the therapist has actually contributed through some error, then making use of the issue to learn about yourself will be more difficult. It will take acknowledgment on the part of the therapist and freedom to air your feelings, before you will have much chance of seeing past the therapist's mistake to glimpse aspects that relate to your own unfinished business.

If you get a reaction that is not professional, one that is judgmental or retaliatory, it will need to be worked through to your satisfaction, or you should consider a consultation with an experienced professional who can bring some objectivity and dispassion to your dilemma. Tell your thera-

pist you are seeking another opinion. A professional therapist should welcome outside input.

Do Therapists Care?

Yes. Therapists, like teachers, I suppose, get attached to their patients. We are invested professionally in doing a good job, but helping you to let us in on your life necessarily creates empathy and that leads naturally to real caring. People who are in a service business usually have clients they don't like. We have a way around that. Once we identify an irritating characteristic as an issue to be worked on, it is no longer irritating. That makes for a part of the satisfaction of the profession, that we get to like just about all the people we work with.

Will we miss you when you are gone? Again, I think we are like teachers. The last day of school is full of sadness for teachers. We miss our patients, too. Do we think of you outside of sessions? Yes, we do that, too. And when we get together as colleagues, what do we talk about? Our patients.

If you liked this book, please consider:

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Appendix

The Scarsdale Psychotherapy Self-Evaluation (SPSE)

Introduction

How do you know if your therapy is working successfully? The Scarsdale Psychotherapy Self-Evaluation (SPSE) is one way you can look at therapeutic effectiveness. Each item in the self-evaluation focuses on an aspect of therapy believed to be related to results. The intent of the self-evaluation is more to help you think about what is important in your therapy rather than to come up with a specific numerical value.

This tool is unique in that it is designed to be independent of the theory or school your therapy may follow. Instead, it is based on universal processes and principles as described in this book.

You will be asked to rate statements in three categories: The Therapeutic Relationship, The Tasks of Psychotherapy, and Do You Feel Safe in Therapy? In all there are eighteen items, each to be scored on a scale of 1 to 5 with 5 being the most positive.

Part One: The Therapeutic Relationship

1. First few sessions felt "right" (Score_____) This has been shown to correlate with overall success of therapy. If you tend to give too much benefit of the doubt or not enough when you first meet someone, ask yourself if your first impression of this therapist is better or worse than your first impressions of other people.

2. Therapist shows "accurate empathy" (Score_____) Empathy isn't just being nice. It is a natural connection that occurs when you are able to let the therapist in on your personal world and the therapist understands just what you mean on an emotional level.

3. Therapist warmth (Score_____) Therapist warmth has been confirmed through much research to be correlated with therapeutic success.

4. Therapist "realness" (Score_____) Humans are very sensitive to others being fake. Falseness or artificiality creates a barrier to any real connection and prevents empathy from working, while realness makes it easier for a patient to open up.

5. Therapist helps me take healthy risks (Score_____) Almost all change processes involve emotional risk-taking when doing so is not really dangerous. Effective therapists help you feel connected and safe and push you a bit to go ahead.

6. Therapist has a plan, a focus, and direction (Score_____) Effective therapies feel like they are going somewhere. If yours doesn't give you a sense of direction, then raise questions about it. Some therapists tell you explicitly what to expect and work with you to develop a kind of contract. In other traditions, you follow a method that in itself gives direction and focus. Whether it is said out loud or not, therapy should soon feel like it is leading you in a purposeful way towards what you want in life.

Part Two: The Tasks of Psychotherapy

Each of these items asks you to rate the performance of your therapy on one of several core tasks. Sometimes you may do a task without even noticing and sometimes you may have to work quite hard at it. There may be some overlap between tasks. Score how well your therapy is helping you do each task or mark "NA" if an area is not relevant to the work you are currently doing.

7. Stop "running" from feelings (Score_____) There are many ways we avoid feelings, and they all interfere with healing and growth. Negative behaviors, rationalization, keeping busy all the time, acting out instead of feeling, even anger can be cover-ups for pain. How well is your therapy helping you to stop running and to face your uncomfortable or painful feelings?

8. Healing your shame, fear, anger, and pain (Score_____) When you hold an uncomfortable feeling for at least ten seconds in a context of safety and connection, the feeling (or at least a portion of it) is transformed and no longer has the power to generate the distress it once did. This is what I call catharsis, the most common and important healing process in therapy. How well is your therapy helping you to use catharsis to heal your difficult feelings so they no longer hold you back?

9. Gain knowledge of yourself (Score_____) All therapies depend on some kind of understanding. Progressing from a vague sense to a clear concept gives us a handle on ourselves. How well is your therapy helping you to make sense of your problems and how you can heal and grow?

10. Reform your conscience or core values (Score_____) Our superego or conscience judges things according to strongly internalized templates. These templates include values, attitudes, ideals, and prohibitions. When we live up to them, we feel pride. When we don't we feel

guilt or shame. The problem is that sometimes those templates are wrong or unhealthy. When they are, we may feel shame or guilt when we shouldn't. How well does your therapy help you identify and resist unhealthy values and judgments?

11. Voluntary Behavior Change (Score_____) Behavior patterns can undermine our lives by covering up feelings we need to face and by supporting unhealthy attitudes or values. Many kinds of dysfunctional behavior patterns can sabotage your life. Most of the time these started out as ways to shield you from feelings that once were too much to handle. How well is your therapy helping you to make healthy changes in behavior?

12. Reevaluate secret wishes and plans (Score_____) Do you repeatedly find yourself blocked from the things that are most important to you in life? Could you be sabotaging yourself? If so, you may have a secret world of wishes and plans in conflict with secret prohibitions. How well is your therapy working to help you clarify these issues and get unstuck?

13. Restart arrested development (Score_____) Regardless of your age, growing emotionally and maturing involve taking emotional risks, practicing new behaviors, and going through the feelings that result. Often pride and shame block us from recognizing areas of immaturity. How well is your therapy working to help you face areas where you need to grow, practice more mature behaviors, and go through the uncomfortable feelings that accompany change?

Part Three: Do You Feel Safe in Therapy?

14. Therapist makes it safe to criticize or disagree (Score_____) This is important in any therapy, and may be the key to resolving unfinished business from the past that has been "transferred" to the therapeutic relationship. Therapists should put personal feelings aside and work with

you to see what part of the problem is yours and what part is theirs. How well is your therapy working to help you resolve difficult issues with your therapist?

15. Therapist makes it safe to share highly personal material (Score_____) Many thoughts and feelings come up in therapy both from the past or in the present, including feelings related to the therapist. Therapists need to be respectful and professional while making it as easy as possible to make these feelings part of what you talk about. Sometimes the therapist's feelings and emotional reactions may be part of the interaction. These, too should be handled in a way that keeps the focus on your treatment.

16. Therapist only makes promises that can be kept (Score_____) Therapists can be tempted to promise more than they can realistically deliver. However, you need and deserve a therapist who will be reliable and firm, even if you are putting on pressure. When promises are broken, it is hard to forgive, and the relationship may be seriously damaged. How well does your therapist manage expectations and set limits?

17. Therapist avoids setting bad precedents (Score_____) Bad precedents are similar to unrealistic promises but are unspoken. For example, if your therapist goes along with you in avoiding an important task—say, not addressing a certain difficult area—you may feel better in the short run but see your progress blocked in the long run. How well does your therapist avoid setting bad precedents?

18. Therapist maintains safe boundaries (Score_____) Therapy is about you, not the therapist. The reason why therapists don't tell you too much about themselves is to avoid making the therapy about the therapist and his or her needs and to keep it focused on you. Physical boundaries are maintained to prevent arousing natural feelings that have the power to take the focus away from your healing and growth. If it feels as though your therapist is dealing with you in a way that is (or feels) inappropriate, or if his or her self-interest is getting in the way, then you can be

hurt and your therapy damaged. Do you feel safe about the boundaries in your therapy? If you have questions, talk to an outside person you trust.

People and Resources

Brach, Tara: She is a psychologist and proponent of Buddhist meditation. More relevant for our purposes, she understands and teaches compassion and "radical acceptance," the title of one of her books. She is a model for the right attitude for healing deprivation from long ago.

Bradshaw, John: An important author, especially within the recovery community, he popularized the idea of the inner child. He also recognized the importance of working with shame. A recent book is *Healing the Shame that Binds You* (2005)

Chorpita, Bruce: A prolific researcher and writer in the treatment of childhood anxiety, he introduced the concept of Modular Therapy, matching techniques to specific situations within psychotherapy as opposed to over-general cookie cutter solutions.

Duvarci, Sevil and Nader, Karim: Pioneering researchers in how fear memories can be erased in the hours following intense recall. They published the classic article, "Characterization of Fear Memory Reconsolidation" in 2004.

Ecker, Bruce: A marriage and family therapist, he has embraced and promoted the idea that memory consolidation is a central mechanism in therapeutic change. He also discusses how therapy can change the faulty

assumptions behind what I call hidden agendas. A recent book, *Unlocking the Emotional Brain* (2012) gives good explanations.

Greenberg, Leslie: Before he founded Emotion Focused Therapy, Dr. Greenberg had come to the belief that avoidance of emotion was the primary source of human psychopathology, and that healing emotional pain was the key to therapeutic gains. He has done extensive research and teaching in the tradition of experiential therapy.

Kandel, Eric: A pioneer in the discovery of how memory is encoded in the brain. His book, *In Search of Memory: The Emergence of a New Science of Mind* (2007) tells the story.

Levine, Peter: An important pioneer in exploring how humans respond to trauma. He has shown how pain and bodily sensations from trauma can become locked in the body and how they can be released. With Bessel Van der Kolk, another giant in the trauma field, he has written *Trauma and Memory: Brain and Body in a Search for the Living Past (2015).*

Linehan, Marsha: Founder of Dialectical Behavior Therapy, an adaptation of CBT to situations were strong emotions need to be worked with for treatment to succeed. This is known as a "third wave" behavioral therapy. There are many books and articles on the subject by her and others.

Miller, William and Rollnick, Stephen: Originators of Motivational Interviewing, a technique for counseling people in giving up smoking and other negative behavior habits. Their method focused on how to avoid a tug-of-war with the patient's free will by acknowledging ambivalence and "rolling with the resistance."

Norcross, John C.: A researcher on psychotherapy and advocate of integration of different techniques and schools. He has written a popular book on behavior change, *Changeology*, (2012) and *Psychotherapy Relationships that Work,* (2011) on factors that determine success in psychotherapy.

Panksepp, Jaak: A pioneering researcher on the neurobiology of emotions in mammals and humans. He is one of the few to recognize that mammal's feelings are essentially the same as ours. His recent book, *The Archaeology of Mind* (2014), summarizes 30 years of work in a somewhat technical but incredibly important contribution.

Pascual-Leone, Antonio: A leading psychotherapy researcher who has championed the idea that many of the gains of psychotherapy consist not of repairing faulty memories and associations, but of creating entirely new patterns in a process akin to normal psychological development.

Schore, Alan: An important writer and thinker who has worked exhaustively to bring neuroscience together with sophisticated psychodynamic thinking. He identified the right prefrontal cortex as the seat of the conscience and has chronicled its neurological development.

Schwartz, Richard: Initiator of the Internal Family Systems Model of therapy, he went beyond Bradshaw to detail how seeing ourselves as having different parts is helpful in therapy and healing. His books are mainly for professionals.

Wachtel, Paul: A central figure for the past 30 years in the integration of different therapies, a founder of SEPI, the Society for the Exploration of Psychotherapy Integration, and a teacher of integrative psychothera-

py, he has elaborated the theory of cyclical psychodynamics, in which work with behavior alternates with work on relationship and feelings. He has written many books including the recent, *Cyclical Psychodynamics and the Contextual Self,* (2014).

About the Author

Jeffery Smith is one of those psychiatrists who still talk to patients. His focus on personal change has led him to a fresh and comprehensive view of how therapy works, the Affect Avoidance Model. Today, he maintains a practice and provides consultation and second opinions to individuals and families seeking the best approach for dealing with complex psychological problems. He does treatment in French as well as English, his native language.

As a freshman at Stanford, Dr. Smith knew he wanted to become a therapist. A native Californian, he received his MD from UCLA, then came east for psychiatry residency at Albert Einstein College of Medicine, Bronx, NY. He is a Distinguished Life Fellow in the American

Psychiatric Association and Associate Clinical Professor of Psychiatry at New York Medical College.

Dr. Smith is an active writer, editor and teacher on the subject of psychotherapy and has appeared on 60 Minutes and Good Morning America. His book, *How We Heal and Grow: The Power of Facing Your Feelings* is "a definitive guide to personal change." He blogs on Psychology Today's website and on his own, www.howtherapyworks.com.

Currently he serves as Newsletter Editor for the Society for the Exploration of Psychotherapy Integration (SEPI) and is working on a textbook for therapists based on the Affect Avoidance Model.