INTRODUCTION

When the Center Cannot Hold

Dashing out of the office and down the hallway, my patient raced toward the elevator. He had threatened his roommates with a knife but was afraid of me. I didn't know what I said that had scared him. So, I ran after him, stood outside the elevator, and put my foot in the door. After I calmed him down, he came back to the office.

Over the following months, we did not discuss his fear that I would invade his mind. Instead, we spoke about space invaders from other planets. We didn't talk about conflicts with his roommates. We explored the practicalities of sending up rocket ships to intercept space aliens. That way, we could make sure the extraterrestrials were safe before their spaceships came down to Earth. He stopped threatening his roommates with knives.

Another patient, a traumatized woman, described a man she had dated. She panicked and stared at the ceiling. Her cheeks puffed, and her lips closed. Her eyes widened with fright. She swallowed, then gasped, "I almost threw up." While describing her boyfriend, anxiety flooded her. Later, we learned that remembering her boyfriend evoked feelings toward a father who had beaten her and a fiancé who had betrayed her. And, on another occasion, in Rio de Janeiro, kidnappers held her at gunpoint on a bus, abducted her, drugged her, and raped her. More emotions rose than her body could bear or her words express.

A third patient, a man recently discharged from a psychiatric hospital, came to our clinic. His parents, convinced he was possessed, had him exorcised. I asked what he felt toward them. His eyes darted every which way. "What is happening?" I asked. He said, "The devil is trying to tempt me."

His parents delivered him to the clinic because he kept hallucinating the devil.

Unable to bear anger inside himself, he perceived it in a demon outside, flitting about around us. No longer a "bad" boy possessed by anger toward his parents, he could be a good son tempted by the devil. He gave up his anger to keep their love but had to lose his sanity to do so. His defense of hallucinating was "the gift of love" he offered (Benjamin 1993): "If I love you by removing my feelings, can you accept what is left?" What horrific prices patients pay to keep the people they love in their lives.

DEFINING FRAGILITY

What do we mean when we say patients are fragile? Due to past relational traumas, current relationships activate powerful, unresolved feelings. These strong emotions evoke overwhelming amounts of anxiety. Flooded by anxiety, these patients cannot hold their emotions inside. So they split off some feelings as "not-me." Then they relocate those feelings outside themselves using a strategy, or defense mechanism, called *projection*. My space invader patient, who could not bear his own anger, imagined his roommates were angry with him. Since he feared for his life, he scared them with a knife.

Sometimes people say they feel fragile. Thus, the term *fragility* is both a metaphor patients employ and a theory therapists need. Theoretically, *fragility* refers to a weakened ability to bear overwhelming feelings when clients' customary coping strategies collapse. Once these defenses break down, fragile clients drown in anxiety. They may become confused, dizzy, faint, or even run out of the office. They feel as if they are falling apart. And, in a way, they are. Their anxiety regulation fails. Their ability to put feelings into words disappears. And their capacity to differentiate fantasy from reality vanishes.

Stresses, losses, and the pain of life overwhelm these patients with unbearable affects (Garfield 1995). And for some, when the heartache is too much to bear, all that may be open to the sufferer is killing off the pain through drugs, murder, suicide, or psychosis. When a person cannot alter the world, he cannot stem his overwhelming pain, feelings, or anxiety. He can escape only through action or imagination.

He cries out for help yet slaps away the outstretched hand he fears will smack him. Dreading rejection, he conceals his need. The pain so great, he cannot bear to feel. He dares not think. And, yet, inside his heart, he yearns to be known.

The crisis causing the deluge of feelings is usually the loss of a crucial person, either through death or a severed connection. Feeling rage toward the person he loves and lost, he protects her either by attributing his rage to others, turning the rage upon himself, or turning it toward any person he meets to rebuild the missing bond. He feels helpless because he is. His higher-level defenses, having failed, have left him engulfed in anxiety. And the discovery that he is not loved by the person he loves has evoked the earliest memories of despair. Feelings from every region of his past arise, flooding over every defense he can find.

When higher-level coping strategies give way, fragile patients try to leave their pain by viewing a feeling as "not-me" (Sullivan 1953b). The suffering into reality is too much. Rather than hold an emotion inside, they split it off and experience it outside: "You are angry; not me!" Yet the implicit message is "If I can't leave the world behind, perhaps I can leave my pain behind, and depart from the heart that suffers." Splitting and projection remove their painful inner life and relocate it into the cosmos. The client sees feelings outside in others and forgets they reside in himself. But when he exports his feelings or impulses onto another person, he no longer relates to her as she is. Instead, he interacts with the picture he has projected upon her: a supposedly angry person. As a result, the fragile patient feels paralyzed in a world populated by his projections. He longs for love but perceives only the images he has placed upon people. As a result, he lives in perpetual fear or anger.

Of course, all of us at times attribute feelings or ideas to others. But when projection blinds the fragile patient, he can lose sight of the difference between the other person and his fantasy about her. Absorbed by his belief, he loses touch with the loving person he knew, and thus, reality.

When trapped by these automatic, unconscious reactions, the fragile patient cannot respond to reality because he is reacting to projections. Anxiety and projections direct his life without his conscious control.

He has no access to the acts of will (Rank 1930/1936) by which we create ourselves (Berdyaev 1944) and give meaning to our lives (Frankl 1959). Anxiety interferes with his freedom to engage in self-creation. He has become determined, in large part, by defenses—ways he protects himself and others—of which he is unaware. He longs for a different life but cannot see the projections that imprison him. His ability to survive trauma testifies to his great resilience, but his further wish to thrive is blocked by invisible obstacles.

Our task as therapists is to help fragile patients recover their freedom to love, to live, and to create a life that matters. We can mistakenly imagine that only their history, diagnoses, and genetics determine their lives. If so, we relate to dead concepts rather than living persons. Instead, we must mobilize the self-creative capacity to act.

We can create a beautiful life full of meaning or a desperate life full of suffering. At each moment in therapy, we have a choice. We can help clients see how defenses misdirect their lives so they can direct them. Then they no longer live a life on the run from their projections. Fragile people do not seek suffering, but defenses guarantee it. When we help people see how defenses cause their suffering, they can recover.

THE NATURE OF SUFFERING

To help the fragile patient, we must understand the difference between *pain* and *suffering*. In life, pain is inevitable. Everyone we love will die, and everything we have we lose, either before or at the moment of death. We can respond to the unavoidable pain of life in two ways. The person whose heart has been broken and gives up loving acts as if her heart is empty. But her heart is full of pain she fears to face or feel. She fears, "If I let myself love, you will leave me in grief. I can't awaken the pain of my past again." On the other hand, the person with a broken heart who continues to love has a full heart. And she accepts that with every love, we swallow the losses inflicted by death or desertion. Hence, our hearts are always full. The question is whether we face the fullness of a broken heart or whether we suffer by hiding our wounds with denial and projecting our pain into other people. But when we hide from the pain of life, we suffer in fear rather than live in love.

Fragile patients are no different from any of us facing the universal struggles of life. As H. S. Sullivan (1947/1966, 7) said, "We are all much more simply human than otherwise." It takes courage to face our hearts, the openness we are. Love exposes us to the pain of loss, rage, and guilt in what Keats (1891, 255) called this "vale of soul-making." When we hate the experience of life, we try to push out the inexorable pain. Defenses attempt to anaesthetize us against the losses of life. We avoid love because it opens us up to sorrow. But love embraces the pain (Symington 2006). As the poet Rumi once said, "Step into this pool of blood that is my heart, but be careful not to splash." Dare we step into the patient's pain, which, in the end, is our own?

The reality of loss and disillusionment is the very warp and woof of our web of relations. Desires arise in each of us. Yet our loved ones can meet our wants in only one of three ways. They can deliver, delay, or disappoint. They cannot always want what we want. And even if they want to give us what we wish, they may not be able. The conflict between desire and reality is ineradicable. We desire what is not here. According to the Buddha, our relationship to desire creates our suffering. Desiring what we cannot have or what does not exist makes us suffer. Our desires collide into reality. People do not want what we want. They cannot always grant us our wish. And our fantasy differs from reality. We finally admit that we cannot give them what they long for, and their fantasy of us differs from the reality of who we are. Moreover, we concede that we are not who we wish we were. We cannot become our fantasy. And as the reality of ourselves slams into our fantasy, our fantasy suffers. And, to avoid the pain of life, we ward off reality and our feelings about it by using defenses.

Reality triggers emotions. If we cannot tolerate them, we avoid the reality that triggers them. But whatever we ward off, we cannot work with. If we help patients bear the feelings reality awakens, they can face them and explore what is possible. The pain of loss, illness, and death is inherent in life. But suffering from defenses is optional—if we learn to see and let them go.

What do we mean by defenses? They are the lies we tell ourselves to avoid the pain in our lives (Meltzer 2009). We avoid feelings through maladaptive thoughts, behaviors, relational patterns, or inattention.

Every effective therapy helps us see what we avoid and how we avoid and then face what we avoided (Weinberger 1995). Once we face what we avoided, we can live into life again, walking into the unknown.

One way fragile patients avoid their feelings is by relocating them on other people. But then they become afraid of people, angry with them, or depressed. Their relationships fail. They interact with their projections instead of relating to their loved ones. The man who projected his anger onto his roommates feared they would kill him. It turns out the Buddha was right. Defenses, our resistance to what is, create our symptoms and presenting problems.

THE CAUSES OF SUFFERING

Let us examine what causes suffering. First, a rupture occurs in a relationship activating our feelings (Damasio 1999). Due to our relational history, certain feelings may make us anxious (Damasio 1999; A. Freud 1936; S. Freud 1923/1961c, 1926/1961b; LeDoux 1998). We can face our feelings and anxiety so we can live into reality (Hartmann 1964). Or, outside of our awareness, automatic defenses may arise, hiding those feelings from us. But these avoidance strategies create our symptoms and presenting problems (S. Freud 1923/1961c). For instance, a father verbally abuses his son. In response, the boy feels angry. He grew up in a fundamentalist Christian family that condemned anger toward elders. Rather than express anger toward his father, he becomes anxious. Then he projects his wish to express his anger onto a hallucination, "The devil is trying to tempt me." He remains a "good" boy with good feelings while the "bad" feeling is in the devil. But his hallucination only reinforces his family's conviction that he has a pact with the devil, no one perceiving how he protects that devil of a father. Thus, he becomes trapped in a purgatory produced by projections.

How do we help him? We offer a secure attachment (Bowlby 1969) where he can safely reveal himself. We ask about the problem for which he wants our help. And we look into his difficulties, their origin, and history. But that might prove impossible. The fragile patient may flood with anxiety before he arrives. He might already assume you are another abuser and equate you today with his perpetrator in the past.

We want to co-create a conscious alliance. But his projection created a misalliance. What happened?

He seeks a healing relationship. But relationships prepared him for pain (Bowlby 1973, 1980). From the first moments of life, the infant is "dominated . . . by the need to retain the mother—a need which, if thwarted, must produce the utmost terror and rage, since the loss of the mother is the precursor to death" (Suttie 1935/1960, 12). For the fragile patient, relational traumas led to repeated experiences of terror and rage. Even if his head has forgotten, his body and heart have not. "There is the hunger for a positive relationship, the rage from past frustrations, and the anxiety of past futilities" (Trunnell and Semrad 1967, 107). He fears you will offer an insecure attachment where he suffers pains from the past. Perhaps his words don't declare this, but his body does. It floods with anxiety. The patient cannot describe his difficulty in words, but the wordless mind of the body reveals it, silently speaking in its secret language: anxiety. Anxiety says, "It has been dangerous to share my problems, opinions, or desires." Defenses disclose how he dealt with this danger: "I must cover whatever you cannot love in me so you can care for the rest of me." In an insecure attachment, the patient adapted by adopting his parents' defenses (Bowlby 1969; Hartmann 1964). Defenses are "security operations" (Sullivan 1949, 1953a), how the patient learned to reduce anxiety in his loved ones to restore security in insecure connections. Thus, when a feeling, anxiety, or defense occur, we observe not only an event in itself but the event and the entire past of the patient (Rukeyser 1949/1996). Feelings, anxiety, and defenses are the poetry of the body, the past to which they refer, and the present enactment of that past. The facts of feelings, anxiety, and defenses are bound together in a natural yet hidden kinship, the recreated relationship with us that brings them together.

These responses of anxiety and defense in therapy are not wrong. Every response precisely expresses the patient's need in this moment. Our task is to discover why his reaction is perfect. If we perceive his need, we can respond to it optimally (Bacal 1998). Excessive anxiety exposes his need for regulation. Defenses reveal how he conceals himself to be loved. If his feelings, thoughts, and impulses were hated, he learned to hate his inner life and expel it into the external world.

If people loved his feelings, he learned to embrace life as he was embraced. So we watch moment by moment to see what elements of the patient's inner life are hated and expelled or loved and embraced (Symington 2006).

As soon as you ask about the patient's problem or his will to explore it, he becomes anxious (S. Freud 1926/1961b; A. Freud 1936). Then he uses avoidance strategies (S. Freud 1923/1961c). He wants help. But his anxiety signals that help hurts. Thus, he may avoid declaring a problem. You may think he resists you when, in fact, he is loving you.

He relates to you according to the rules of insecure attachments. He learned that if he needed help, he was punished. If he declared a separate will or desire, he was condemned. If he had an emotion, he was banished. That's why he avoids declaring a problem, a separate will, or a feeling. He learned to conceal himself to remain in a relationship (F. Evans 1996; Sullivan 1953a). He fears you cannot love him if he doesn't cover up what cannot be loved (Post and Semrad 1965). When he avoids forming a secure attachment, he shows you how he adapted in an insecure attachment (Bowlby 1969, 1973, 1980; Hartmann 1939/1958, 1964; Lyons-Ruth 1998). Hiding, his gift of love in the past (Benjamin 1993), is how he loves you today. He protects you from what he fears you cannot love. He does not resist therapy. He shows you how he learned to love—by leaving his needs behind: "If both of us hate my need, can you love what's left?"

MOVING FROM AN INSECURE ATTACHMENT TO A SECURE ATTACHMENT

These strategies, learned from the first days of life, establish attachment patterns by twelve months of age in an infant (Beebe et al. 2010). These patterns of self-erasure to preserve a relationship were never conscious or intentional. Automatic, unconscious strategies, developed from infancy, take place without the patient's knowledge in adulthood. They saved his life in the past, but they damage his relationships today.

The patient does not avoid you. He tries to avoid the thoughts, feelings, and pain evoked by depending on you. He wants your help. But the need for help and the desire for affection awaken feelings from

the past. These feelings elicit anxiety, which then triggers a defense, and the defense creates his symptoms and presenting problems.

With every patient in every relationship, we find the same pattern:

1. A relationship brings out feelings based on past relationships.
2. Feelings trigger anxiety, a bodily sign that feelings were dangerous.
3. Anxiety mobilizes defenses, how he handles that danger to keep a relationship.

We call this pattern the *triangle of conflict* (Malan 1979; figure I.1). (See chapter 4 for a discussion of the triangle of conflict.)

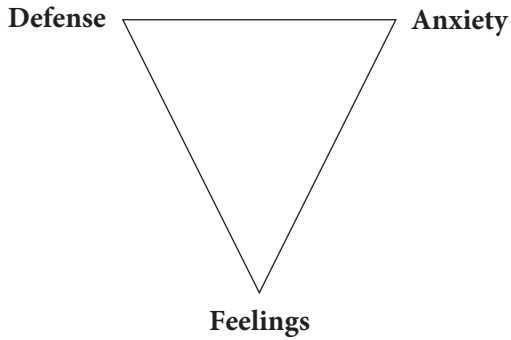

Figure I.1 The triangle of conflict

Defenses previously preserved his relationships. Today they corrupt his connections. They solved a problem in the past, but they produce his problems in the present. We help him let go of these outdated strategies so he can face the feelings he avoided. Through this new experience, we co-create a secure attachment, opening a pathway toward better relationships with others. Figure I.2 illustrates how we can understand the triangle of conflict as the unconscious memory of attachment trauma.

Everything the patient says in the session expresses this relational pattern: (1) feeling-connection, (2) anxiety, and (3) defense-avoidance. He initiates the bond by offering a problem. If he declares a problem, we encourage him to explore it to get to the bottom of his difficulties. If he is too anxious, we regulate his anxiety because it is safe to explore only when he feels safe. If he uses an avoidance strategy, we help him see it and its cost so he can let go of it and receive the help he needs. Then we help him bear together what he could not bear alone in the

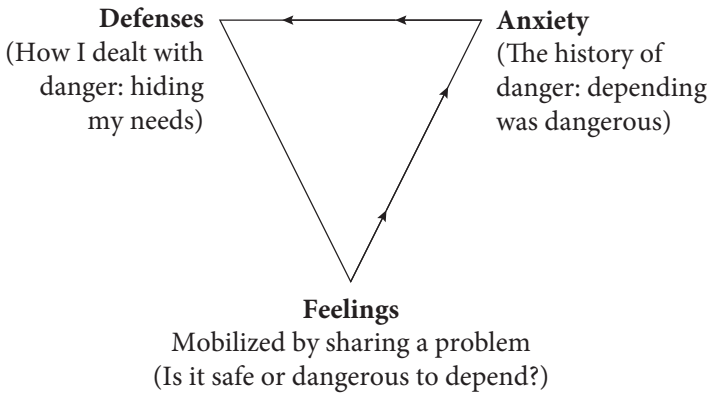

Figure I.2 The triangle of conflict as memory of attachment trauma

past. The principles are simple, but their application can be complex with fragile patients because anxiety can spike, overwhelming their capacity to function.

The three basic principles of psychotherapy are as follows:

1. Invite a healing relationship by exploring the patient's problems and feelings.
2. Regulate anxiety when it gets too high so he can feel safe. Then encourage him to explore the problems and feelings triggering his anxiety.
3. Help him see and let go of the defenses that prevent him from connecting to his inner life and other people. This helps him accept his inner life rather than reject it. Once he can bear the feelings triggered by closeness, closeness becomes possible.

As mindfulness practices have shown, we do not avoid reality or our feelings only occasionally (Safran 2003). Defenses create our suffering all day long. Thus, moment by moment, we help the patient see the defenses that inflict his suffering as they unfold in real time during the session. One might think of therapy as a form of guided heartfulness meditation. We help the client pay attention to his inner life as it arises second by second. Each time he ignores it, we invite him to pay attention to it and return to his problem, his will to work on the problem, or the feelings stirred up by depending on us. As he lets go

of his defenses, they no longer cause his suffering, and the feelings he abandoned embrace him. Each time he pays attention to reality, awareness arises of the presence he is (Eigen 1998). He becomes at one with the emotional truth of this moment (Bion 1970).

Understanding causality makes the therapeutic tasks clear: (1) we help the patient present a problem, (2) we help him declare his will to work on the problem, and (3) we help him propose a positive goal for the therapy. These three steps allow us to co-create a working alliance.

In every therapy session, we see the following sequence. The therapist invites a closer relationship by inviting the patient to share the problem he wants help with. Each invitation activates feelings, which evoke anxiety, which triggers defenses. And those defenses create a symptom or presenting problem in the session. This sequence happens up to 150 times an hour. Thus, we do not say a patient has depression. Instead, his defenses create and sustain his depression. Depression is not a possession; it is a creation.

That's why we try to interrupt automatic defenses that hurt the patient. If we can help him see the defense, understand its cost, and leave each one behind, his symptoms will diminish and disappear. He tries to reveal his need, but defenses interrupt him. We interrupt the interrupters to give him a chance to reveal his inner longings and desires. Interrupting defenses shows our compassion for the patient (S. Warshow, personal communication). We do not collude with the defenses; we collaborate with the person who suffers from them. Never interrupt a person who speaks from his heart; interrupt the defenses that keep his heart from speaking. For when the heart speaks, even the silence sings.

This book will offer many ways we bear and share a person's struggles and suffering, one human meeting another. While you will learn many techniques, they serve one purpose: to encourage a secure attachment. Our interventions invite the patient to bear together what could not be borne alone. By interrupting the interrupters, we show our love and compassion for the patient's inner voice. Defenses invite us to form an insecure attachment. Instead, we invite a secure attachment by relating to the person hidden behind the defenses. Techniques are not things we do to an object but ways we relate to a person. We help him become

free from the archaic strategies creating his suffering so he can take up the path of self-creation that is personality itself (Berdyaev 1944).

His defenses are the ways he learned to reject himself to make his parents less anxious (Sullivan 1953a). Now we help him surrender those defenses so he can embrace his forbidden feelings and desires. Through our compassion for him, he learns to have compassion for himself. In a letter to Carl Jung, Sigmund Freud once wrote, "Psychoanalysis is a cure through love" (Freud and Jung, 1906/1994). And that love is revealed through our faith in the patient's potential. Symptoms draw us down into the depths to the person hidden within. As one woman said to me, "You saw who I was underneath all the chaos and defenses before I knew there was a me to be found."

LOVING AND FEELING

Why didn't my patient know there was a self to be found? I asked a sculptor what she wanted me to help her with. In response, she filled with anxiety and hallucinated that the walls were moving. Later, she disclosed that her mother had tried to drown her in a bathtub. No wonder she was afraid to depend on me! Depending nearly led to her death.

I asked a painter if it was her will that we work together on her problem. She became anxious and dizzy. Later, she described a fight in which her father put a pistol to her forehead. Why did declaring her will trigger so much anxiety? Will—a separate mind—meant death.

Fragile people often suffered traumas when they counted on caretakers, declared a separate will, or had a feeling, so we help them step by step. First, we regulate high levels of anxiety. Then we help them declare a problem and their will to work on it. As they explore their problems, we help them share their feelings with us. Why?

Feelings express our primary motivations and drives (Kernberg 2001; Tomkins 1962). Without them, we lack a compass to show us where we want to go in life (P. Coughlin, personal communication). Infants do not have words, but communication still takes place. "*Emotions are* that channel of communication" (Symington 2006, 26). "[E]motions *are* the relationship," that connecting link that gathers us together (Symington 2006, 31). Yet fragile patients had to hide their

feelings, the specific link that made their parents anxious (Sullivan 1953a). To survive, they let the emotions and desires of others be the compass of their lives (Lacan 1966/2007; Laing 1959/1965; Searles 1965/1986a). Sadly, they *had to* abandon themselves not to lose the one they loved. They had to conceal an emotional link to keep the emotionally stripped link their parents could bear. Instead, we help them accept their inner life, their emotions, and their link to us while we accept their inner life and our own.

In therapy, we help the patient find the truth of who she is. In the past, she had to hide the truth to be loved. Now we help her face and let go of her defenses. Then she can accept the truth she sent off to live in others that always lived in her.

Yet to help the patient embrace what others could not cradle in her, the therapist must embrace those aspects as well. We cannot help patients face issues we cannot confront in ourselves. We will help them avoid like we do. Anything a person fears and shares is part of our mutual humanity. We can embrace the patient's pain, or we can ask her to hold it alone, while we distance, judge, or try to control it. But a person is never a foreign object we observe from afar. She is a fellow human with whom we share the same feelings, longings, and struggles for connection. For "whatever we know intuitively is not an object, it is part of our own being" (Chaudhuri 1987, 32). The therapist's embodied acceptance invites the patient to accept her inner life (Symington 2006). And in our meeting, the patient's suffering—unbearable while alone—becomes bearable with us together. And that occurs through *compassion*, a word from the Latin meaning: "to suffer with." By relating, we share the pain of the patient's life so we can acknowledge, bear, and put it into perspective (Semrad 1966). And why use the word *patient*? It comes from the Latin, meaning "one who suffers." Compassion is not a cognitive skill but a mutual emotional living through (Fiscalini 2004), a co-suffering of the patient's conflicts, our universal conflicts. Our bond is the broader human perspective, where suffering becomes knowable and shareable. What was harmed in a relationship must be healed in this relationship. "What went wrong must go right" (D. Malan, personal communication). However, as we co-create this connection by bearing our shared humanity, therapy can feel dangerous to the patient

due to anxiety and projection. Thus, we must first co-create a sense of safety. To do that, we regulate anxiety, the subject of chapter 1.

RECOMMENDED READINGS

Abbass, A., Town, J., and Driessen, E. (2012). Intensive short-term dynamic psychotherapy: A systematic review and meta-analysis of outcome research. *Harvard Review of Psychiatry*, *20*(2), 97–108. http://www.istdpinstitute.com/resources/.

Coughlin Della Selva, P. (1996). The integration of theory and technique in Davanloo's intensive short-term dynamic psychotherapy. In *Intensive short-term dynamic psychotherapy: Theory and technique* (pp.1–25). Wiley.

Coughlin Della Selva, P., and Malan, D. (2006). Empirical support for Davanloo's ISTDP. In *Lives Transformed: A revolutionary method of dynamic psychotherapy*, (pp. 34–74). Karnac.

RECOMMENDED MATERIALS

For information on forming a therapeutic alliance presented in videos by Jon Frederickson, visit the URLs below.

Intensive short term dynamic psychotherapy part 1 (October 5, 2011). http://www.youtube.com/watch?v=cKzmk2-xnzY

Intensive short term dynamic psychotherapy part 2 (October 5, 2011). http://www.youtube.com/watch?v=dK2x906ptWA

Intensive short term dynamic psychotherapy part 3 (January 18, 2012). http://www.youtube.com/watch?v=sDmVgoKPVkw

Visit the Intensive Short Term Dynamic Psychotherapy (ISTDP) Institute for introductory skill-building exercises for working with fragile patients at http://istdpinstitute.com/resources/skills-for-working-with-fragile-patients/.