The Ten Reasons Not To Change

Ross Ellenhorn, LICSW, Ph.D
Owner and CEO, Ellenhorn

Years back, I led a therapy group in a day treatment program for people who all had extensive histories in the mental health system. This was an open group, so new participants were always coming and old ones leaving. Over time, I began to wonder about one specific issue: Why did participants in the group consistently resist changes in their lives that seemed so obviously positive? I repeatedly asked the participants this question over the span of years. No matter who was attending these groups, their responses were remarkably the same. I documented these responses, calling them "The Ten Reasons Not To Change." The Ten Reasons Not To Change captures, what I call "the paradox of disappointment": how a person who has experienced considerable setbacks might become afraid of the very thing that motivates most of us -- hope.

Disappointment and the Fear of Hope

"That movie was a disappointment"; "I had a disappointing meal last night"; "I'm disappointed by your behavior, young man!" The word "disappointment" is so often used for mundane observations, yet there is no better word for the experience of a dream unreached. Disappointment, used in this sense, is awful. We are crestfallen when we hope big and are then disappointed.

We often call disappointment "crushing" for a reason. At its root, the word *disappointment* means to fail to reach an "appointed" goal. That is why when we dare to dream, we risk getting hurt, even being damaged. So dreaming requires a sort of courage.

If we don't dream, we lack the motivation to move forward, but we also avoid the pain of disappointment. If we do dream, we come alive, our morale rises and we begin to move; but we also risk losing something we have *appointed* -- that is, identified or pointed to -- as valuable and life-giving. Thus, we risk the awful recognition that we lack the power to actuate our dreams. The result can be a profound, almost unbearable disappointment with *ourselves*.

Totalizing and deep disappointment—hope's foe, hope's *raison d'être*—is a silent danger every time we take the risk of action. When the infant reaches for her mother, she risks the disappointment that the mother will not respond, or that the infant will not be satiated. When she cries out from her crib, she risks that nobody will come, or that they will be too tired, too preoccupied with other matters, to properly soothe her. When a baby smiles into her parent's eyes, she risks misattunement; when she reaches for an object, she risks that the environment around her will lack integrity and durability. When the child first speaks, she risks that no one will listen; when she tries to make friends, she risks rejection; when the young adult leaves home, she risks that she will fail at being an adult; when she starts out towards a career, she risks that she's made the wrong choice, or will not be competent enough to succeed. When the artist puts paint to canvas, she risks a disappointing work; when she shows the painting to someone else, she risks their disapproval. When two lovers take the first steps towards intimacy, each risks disappointing the other, and each risks finding the other disappointing. As I write now, I risk disappointing you, and becoming disappointed in myself. What fills the space between these perennial risks and action? Hope. It moves us forward despite the ever-lurking possibilities of disappointment.

When experienced as a singular event, most disappointments have little effect on our capacity for hope. But repeated disappointments often cause us to see hope as actually dangerous, a fast-moving straight road to more failure. Thus, repeated disappointment makes hope a central threat to one's sense of psychological security.

This crushing kind of repeated disappointment is a central element in what I call *psychosocial trauma*—the social injuries that are always a potential result of being diagnosed and viewed as mentally ill. In fact, the chief complaints of people who receive treatment for mental illness are often about disappointment and dreams deferred: "My friends are moving along, and I'm standing still;" "I thought I would be graduating by now;" "People tell me I have to lower my expectations from where they once were." As their dreams are repeatedly unmet, a person's disappointment often turns inward. A sense that dreams have failed turns into a view of oneself as a hopeless failure as a human being. As disappointment becomes part of the person's identity, they turn away from hope, since hope only promises more disappointment and thus more painful reminders of their failings. Turning from hope, they also turn from aspiration and avoid moving forward. They no longer trust the world. They no longer trust hope. Their position in life is understandable but perverse: Thirsty, they view the well of hope as poisoned. And here lie the rub: The more they see the disappointment that can result only from hopeful acts, the *more they see staying the same as their most trusted sanctuary.*

Let's review the Ten Reasons Not To Change.

REASONS NOT TO CHANGE: ONE THROUGH SEVEN

We all grapple with the first seven Reasons Not To Change, whether or not we've been diagnosed with or treated for a mental illness. In fact, for all of us, our willingness to change often depends on how we weigh the following seven reasons. However, while we all grapple with them, they can appear more solid, heavy and unmovable for someone who is thoroughly afraid to hope. For this person, the risk of disappointment outweighs the benefits of moving forward. He or she comes to see staying the same as the safest route.

Reason One: Raising one's own expectations about change

When we change something for the better, we always risk disappointing ourselves if we can't maintain the change. This is an unavoidable fact about change. When we change our life, we risk failing to meet the expectations generated by this change. Keeping our expectations low is a central means of avoiding this possibility. If we do not have high expectations for ourselves, there is little possibility of disappointment.

Here is an example from my own life: Right now, I'm sitting in my home office and it's a bit disorganized. I know from my past failures that if I clean my office, it will quickly become messy again. But I also know that I can avoid the feeling of failure that comes when my clean office becomes messy by avoiding cleaning my office. If I keep my office messy, I live in one failure (the current state of messiness) instead of two (messiness plus yet another failure to keep it clean). I also trade the background drone of long-term failure to be neat for the pain of making change, then raising my expectations about myself, and watching myself fall from my new exalted status as Man with a Clean Office. In this situation, staying the same feels safer to me than change.

When a person has experienced significant disappointments and sees underachievement as part of her identity, her fear of raising her expectations and thus, risking disappointment can become overwhelming. After many setbacks, she sees failure in *one* area of her life as reflecting her overall failure *at life*. Even the smallest mistake becomes a reminder of her global identity as a failure. That is why even simple successes, with their threat of raising her own expectations and thus increasing the risk of being slammed down by failure -- become quite frightening.

Over the years, I see otherwise smart and capable clients struggle to accomplish the smallest tasks: cleaning their homes, exercising, eating right, getting out into the community, and doing homework. Although these people assertively set goals for themselves, and talk enthusiastically about how they want to achieve these goals, they are often unable to do so. Raising their sense of hope and thus raising the risk of disappointing themselves is the dynamic that pulls them back. The issue for them is not motivation *per se*, for they are motivated to have a better life. Rather, it's a matter of their sincere desire to change encountering an even more powerful force -- the fear of disappointing themselves.

Here is a case example: After years of fighting his parents and his psychiatrist over taking his medications, our client, John, agreed to do so. Taking the medications, however, caused him to gain weight. John felt bad about his appearance, and was embarrassed to see his friends. Like many of us on a diet, he was motivated to lose weight, but each time he tried to exercise or eat right, he fell short. Finally, he gave up the attempt to lose weight. Predictably, he gained more weight, becoming dangerously obese.

I believe that each time John failed at losing weight, he faced his general sense that he is a failure, his chronic disappointment in himself, and his guilt. Wanting to avoid these awful feelings, he avoided change. Staying overweight became a better solution than feeling disappointed.

But only for the time being.

As you will see, when others around him began to focus on his weight, John came up with another, more complex solution.

Reason Two: Raising the expectations of others

As a Man with the Clean Office, I will not only raise my own expectations; I'll likely raise my wife's, too. She'll be excited by this change. And if I fail at keeping the office clean, she will witness this failure. That will feel bad – for both of us. So one way to avoid disappointing her is to keep the office messy. This is another fact about change: *By making a positive change in one's life, a person not only raises his own expectations; he inevitably raises the expectations of others. Doing so, he risks that others will witness his failure to maintain the new, more positive status he has achieved.*

For a person injured by repeated disappointments, the risk of failing in the eyes of others is akin to the risk of disappointing himself. People around him are focused on change, waiting for him to take the next step. They develop treatment plans aimed at change, or offer suggestions on what to do. He knows they see any change as a positive sign of his overall recovery. But the opposite is also true: Any failure at even a small task will be viewed as a global step back. For someone in this situation, staying the same seems quite attractive.

Let's return to John's situation. Obesity is a main cause of early death for psychiatric patients. John's parents were thus rightly anxious about his weight gain. They talked to him repeatedly about it. In fact, their anxiety about his weight pervaded many of their interactions with him. Every time John visited his psychiatrist, the psychiatrist also commented on the need for him to lose weight. "You are on medications that can cause diabetes or dangerous cardiac conditions," the psychiatrist told him. "We need to develop a plan for you to reverse this trend." One can imagine that John often left his psychiatrist's office feeling ashamed of himself. And most likely, he hated to hear about his weight from his parents.

I believe John genuinely wanted to lose weight. But he also probably knew all eyes were on this goal, and he couldn't stand the idea of disappointing the people around him. By keeping the weight on, he could avoid raising their hopes, then disappointing them. However, as their pressure on him to change increased, John took a different tack; he could lose the weight while also protecting himself from high expectations with one swift move: stop taking his medications. In fact, by ceasing to take his medications, he actually killed two birds with one stone. Now that everyone's eyes were on medication compliance rather than weight gain, what they expected of John was a step *back* from the pressure of their previous expectations—a safer place to be for John. John also lost weight, and his physical health improved.

Reason Three: Facing where you are in life

If I decide to clean my office, I first need to admit that its messiness is a problem of my own making. To clean things up, I confront the mess I made. This dynamic in change is unavoidable: *Progressive change requires that individuals assess what they need to change, and thus confront the current state of the lives they have authored.* This is an expectation in most treatment; a person must candidly evaluate her problem in order to overcome it. It's no coincidence, for example, that the first event at an Alcoholics Anonymous meeting involves people identifying themselves as alcoholics: "My name is Jane and I'm an alcoholic."

That confrontation is particularly difficult for a person who believes her life is a disappointment. For her, evaluating her current situation is the same as evaluating her failure at life.

Many people in my program focus on returning to college as their main psycho-social goal. Often we are rather quickly able to help them regain enough stability to take classes again, typically on a part-time basis, at our local community college or through an extension program. Usually they are able to do well in these classes. But when they contemplate taking the next step, and consider enrolling in a four-year college, they become more anxious and resist moving forward. In the first stage of enrolling, they retreat, don't finish their applications, miss interviews, or simply give up. At this point, the challenge for them is not educational ability, but struggles over change and acknowledging where they are in life.

For them, the acts of searching for the right school or registering convey messages that they have missed out on schooling all the time they did not attend. When they took part-time classes, they were able to keep the hope of returning to school at a safe

distance. They were "trying things out" or "learning for the sake of learning" in classrooms filled with others of various ages, interests, and careers. But once they seriously engage in the process of returning to school, they contend with the idea that their friends have already graduated, that they missed out on the social experience of being in college, and that they are behind in their careers. At this point, many are filled with regret and remorse – poisonous, painful feelings. They can avoid these awful feelings by keeping the return to college as a far-off fantasy, something they talk about doing, but don't put into action.

Reason Four*:* Taking "small steps"

If I start to work on my office, I might discover that the task of cleaning it is larger than I thought. As I continue cleaning, I will be repeatedly reminded of my own tendency to be disorganized. Surveying the artifacts of daily neglect, I'll unearth an entire cupboard of coffee mugs on my desk, a pen that's been missing, and an old book I've been looking for. The repeated reminder of failure that accompanies small steps is always part of change. *To change his circumstances, a person is not merely required to face where he is in that moment, but to do so repetitively, as he takes the incremental steps towards a goal. Each step is a reminder of where he is and how far he has to go to reach his goals.* As we move towards change, we need to face our current predicament at each step of the way.

For a person who has experienced significant disappointments, each incremental step towards change is hurtful; each one reflects his disappointing place in life. When he sees the many steps required to reach his goal, the goal itself is a reminder of his lack of

accomplishment. For example, the person going back to college might have real career goals and a real dream of what he wants to do with his life. But each rudimentary class he takes reminds him both of how far he has to go to finally reach his goal, and how far he lags behind his peers. One means of avoiding the pain of small steps is to "think big" while never really changing: to dream of a career, plan for it, talk about it, but never take the necessary steps to reach it.

Reason Five: Being accountable for "what's next"

My messy office anchors me. Cleaning it is an obligation I must meet before I can do more fulfilling things. It thus keeps me from feeling whole and unencumbered. Offering a false sense that I am constrained, it provides me a kind of pass from the weighty awareness that I'm in charge of my own life, and accountable for making it work -- the sometimes scary prospect philosophers call "existential freedom." If I clean my office, I'm one step closer to this freedom and thus to my own accountability for the life ahead of me. This is a central dynamic of change: *Each change a person makes testifies that she is accountable for the life that lies ahead. The more she changes, the more the outcome of her life is seen as within her power.*

I'm not only guilty of avoiding my existential freedom by dodging positive change; I've been known to place unduly high expectations on my loved ones when I see them change, taking one act of change as a harbinger of more success. When my son calls from college to tell me about a good grade in a class, I always try my best to focus on this single event. Doing so isn't easy for me. I'm like a smoker trying to quit, who is

concentrating on avoiding a very seductive behavior. Somehow, I always end up engaging in my bad habit: I talk to him about other possible successes ahead.

"That's great about the A," I'll say. Then a few minutes later -- and against every nerve in my body -- I'll blurt out, "How are you doing in your other classes?" or "Just think, if you keep that up, you could get an A in the class!" In mutually unsatisfying exchanges that are all too frequent, his comment about one success becomes for me a push toward higher expectations. Meanwhile, my son wants to stop for a second and be recognized for doing well on a particular task. "What's next?" is a parent's prerogative, so I don't feel too out of the norm when I make such comments. But for my son, I'm moving the goalpost.

For a person who lives with a fear of disappointment, the tension between change and the inevitable questions about "What's next?" can be overwhelming. By making a change, she is exposed as an accountable and potentially competent agent in her life. Thus her future – and her potential future failures – are exposed as her responsibility. When, for example, a person begins a job, and works at this job responsibly, she creates the possibility for herself and for others observing her that she can accomplish new things. In this way, she multiplies the possibilities of failure and of feeling and being held accountable for these failures. The best way to avoid this escalating accountability is to stay the same.

Reason Six: Facing the unknown

If I clean my office, and I keep it clean, pick up after myself every day, and make sure to keep it organized, I'm creating something new in my life, something even

unpredictable. This is another way change operates: *By enacting change in one's life, a person faces the unknown possibilities of a life that is in his hands. When we enact change, we must contend not only with an unpredictable world, but also with the unpredictability of the future created in part by our own actions*.

A person wrapped in a feeling of failure sees little information in his past to predict a successful future. For him, facing the unknown means facing a menagerie of possible failures. The fear of a failed unknown is one reason people refuse or neglect to take their medications. By remaining symptomatic, they live with sometimes difficult psychiatric experiences, but these are at least familiar.

For a person who has experienced significant disappointment, the "symptom relief" offered by psychotropic medication is not necessarily *relieving*. Once symptoms diminish, he enters a less predictable world, one in which he can't know what emotions or thoughts lay ahead. He also doesn't know if he will succeed when "healthier," and is afraid of failing while less symptomatic. Though unable to predict a future on medication, he worries that even one failure while symptom-free will be a sign of his failure as a human being. In other words, if he fails when not experiencing symptoms, he can't blame his life failure on psychiatric issues. The blame will instead rest squarely on his shoulders as a person who is inherently failure-making. A quick and efficient means to avoid this problem is to remain symptomatic.

Reason Seven: Existential aloneness

To be completely honest, I'm certain that in my subconscious lies another motivation for keeping my office a mess: If it is messy, I can wait for someone to clean it

for me. Somehow, I find a perverse comfort in hoping someone will help me with the mess. Aside from divine intervention, this will never happen. But the waiting is nice. If, on the other hand, I clean my office, I break the spell of waiting, and recognize what philosophers call my "existential aloneness": my personal accountability to make my life meaningful. *Change always makes us face our own aloneness. Enacting change, a person recognizes that she alone is the author of her life, the originator of things she has made happen in the past, what she is making happen now, and what she will make happen in the future.*

But a person injured by significant disappointment sees only failure in her future behavior. Since the idea that her life "is in her hands" only means to her that she hasn't lived up to her potential, she finds confronting her own authorship singularly unbearable. Seeing herself complete tasks on her own only means being alone with her failure. In fact, anxieties about "existential aloneness" pervade all the above Reasons Not To Change.

A client in my program suffered from severe anxiety and panic. I'll call her Hillary. We provided many treatments for Hillary's problems. Aside from her pharmacological care, we offered cognitive behavioral treatment, psychotherapy, art therapy, and meditation. Hillary would listen to our suggestions during her treatment hours, but during the day, when she felt most anxious, she would rarely apply the skills she learned. She proposed a different technique to alleviate her symptoms: that we call her at scheduled times to provide support. Our program offers 24-hour phone access. Therefore, we explained to Hillary, she did not need to reserve her calls for crises; she could call anytime for support. But this provision of impromptu support did not satisfy

Hillary. She argued that *scheduled* calls during the day – at times when she was most likely to panic — would be more helpful.

Hillary's request was not for more resources. In fact, she wanted fewer (we were ready to take her call any time, for any reason). She asked for something limited: short calls at specific times. Hillary's worst times of anxiety were in the evening, and she especially wanted us to call then and remind her to apply the skills suggested by her many therapists. She asked that we stay on the line with her a bit, and walk her through a particular practice.

Here's what I think was happening for Hillary: Using her learned psychological skills on her own, and asking for help when she needed it (rather than setting up scheduled calls), felt as if she was exposing herself as an autonomous individual. If she used the skills, she would see herself doing something on her own. Others would see this, too. If she asked for help on an unscheduled basis, she and others would witness her requesting it as an independent and accountable person. *She couldn't bear the experience of aloneness that came with these gestures.* The scheduled calls were her way of having contact with us without experiencing her existential aloneness, her need and ability to author her life. As long as we called her at particular times, she could feel *acted upon*, rather than a person taking *action*.

Hillary's predicament – and her solution—offer a gateway to understanding the remaining three reasons not to change. Hillary wanted an agency or program intervening in her problems as if she were the passive target of symptoms. She wanted, in other words, to both cure her anxiety and remain in a passive role.

Hillary wanted to be found, identified, *seen*. But she also wanted to distract others, and herself, from seeing her accountability. This may seem a rather odd position, a superficial way of interacting with the world: all surface, no depth. Yet within the myriad social roles one can access in our society – husband, wife, doctor, lawyer, artist, boss, employee – one role actually sanctions this position: the patient role.

The three remaining Reasons Not To Change concern the particular resources intrinsic to the patient role. A person inevitably loses these resources when she gets better.

REASONS EIGHT THROUGH TEN: THE SECRET BENEFITS OF THE PATIENT ROLE

Think about a time when you advocated for yourself with a health care provider -- either questioned their judgment or gave your opinion on your problem. Even when this provider was perfectly pleasant, wanted to hear your opinion, and treated you with respect, you probably still felt you were doing something wrong, as if you were stepping outside a norm, incorrectly breaking from the patient/doctor script. If you had these feelings, you had good reason. By actively participating in your treatment, you were deviating from your role as a patient.

Every social role is defined by a particular set of rights and responsibilities. Parents, for example, have certain rights, the main one being the custody of their children. Parents also have certain obligations, norms they must follow to remain in the role of parent. The main obligation for parents is the appropriate care of their children. When parents neglect or abuse their children, they deviate from their role. When they do not fulfill their *obligations* as parents, we often question their parental *rights* to custodial

responsibility. If we take their children from them, they remain parents by blood, but they have lost their right to the parental role.

The patient role also carries certain rights and obligations, ones a person must adhere to in order to remain in this role. As the famous sociologist, Talcott Parsons, describes it, the rights and obligations of a sick person are clearly defined by aspects of passivity. In regard to rights, when you are sick, you have the right to be exempt from normal social roles, and you are deemed to not be responsible for your condition. When you call in sick to work, you are behaving within these two rights: You are telling your boss that you have the right to be absent from work, and you are expecting that there will be no negative consequence of your absence, since the illness is out of your control.

Like all social roles, the sick role also comes with specific obligations. It is expected that a person who assumes the sick role will behave like a sick person. If you call in sick to work, you will be deviating from the sick role if you then go out golfing. The assumption is that you will be spending the day healing. You are also obligated to seek help for your condition from a professional. If you take more than a few days off from work, yet do not consult with your doctor, your boss might begin to feel you are not fulfilling your obligation as someone too sick to work. He might question your commitment to getting better. When a sick person does not seek help, we see him as deviating from his role. In psychiatry, we call such people "non-compliant" or "treatment resistant." With other illnesses, doctors might still use psychological terms for their non-compliant patients: "She's in denial about her condition."

Simply put, when one assumes the patient role, he has the right to be passive and the obligation to submit to treatment. When he does not behave in a manner that reflects

these norms, he deviates from his role. For someone suffering an overwhelming experience of disappointment, the very passivity of the patient role is attractive. In fact, for this person, within the infinite universe of roles society offers us, the role of patient is the safest one to assume. It is a safe harbor for him, and it offers many social resources that give him a sense of security.

These resources are considerable. The daily activities and relationships that comprise the social lives of consumers of mental health services mimic basic social, familial, and community supports. The patient role gives a person access to familiar social contacts through ongoing relationships with therapists, other therapeutic workers, and fellow-participants in psychiatric programs; it provides an extended social support network of therapists and peers who recognize the patient, keep track of him, and identify him as legitimately having a particular social role.

In its own unique way, the patient role offers all these resources, while simultaneously defining the person as passive: a non-actor. You can't get that in most social roles. A plumber is a person *doing* plumbing, an architect is a person *doing* architecture, a parent is a person *doing* parenting. But the patient is a person defined by *doing nothing*. In fact, the very ingredients that legitimatize most social roles are a threat to the patient role. The plumber, the architect, the parent, all feel most firmly nestled in their roles when they are as successful as possible at doing plumbing, architecture and parenting. For someone in the patient role, on the other hand, success means getting better, and, as we've seen, getting better for such an individual can feel threatening. Thus, the threat to their role is reversed. Most people experience a crisis in their role

when they fail to perform the acts that justify their claim to that role. But for a person engaged in the patient role, success causes the crisis.

When a person is invested in the patient role, it can feel threatening to move towards greater engagement with others outside therapeutic circles and to be involved in non-patient social activities, since any of these activities call into question his right to the patient role. When, for example, he seeks employment, he deviates from his right to be exempt from such an activity. This calls into question his previous status as someone too sick to work. "If he can look for work today," others might ask, "could he have done the same yesterday?" He is also deviating from his obligation to focus on getting better.

Keeping the patient role in mind, let's look at the remaining three reasons not to change.

Reason Eight: Losing a social support

Treatment aims at life-change and the amelioration of symptoms. It also aims at building strong therapeutic relationships. *When a person makes positive changes in her treatment, she inevitably steps on a path that leads out of treatment, and thus away from these relationships.*

Each of us has lost supportive relationships with people (our coaches, teachers, bosses) due to our growing autonomy. But our increasing autonomy is usually based on changes in our status (we advance to another sports league, graduate from school, are promoted, or change jobs) not on changes in our behavior. In addition, while there may be elements of warmth and intimacy in mentoring relationships, therapeutic relationships often focus directly on developing warmth and intimacy. Thus, in all therapeutic

relationships, there is an intrinsic tension: one between unconditional care and termination that is conditional on change. The message in therapy is that, "We will have a relationship so strong and intimate, it will motivate you to change; a kind of love and security that will enable you to take risks to better your life." But the message is also that "This deep relationship will end once you get better." That is a difficult tension to navigate for someone who is already feeling overwhelmingly alone, and overwhelmingly injured by disappointment. *For this person, the choice between change and loss is threatening. For her, losing treatment means losing vital social psychological resources.*

The patient role provides access to social support that is so necessary for every person's security. The role provides this resource while maintaining low expectations regarding existential accountability. Thus, relinquishing the patient role means not only leaving a sense of community, friendship and way to identify oneself to others, but moving on to a more accountability-driven state. For someone who wants community, but is terrified of accountability, treatment offers plenty of incentive to stay the same.

The patient role provides two other resources well-suited to the needs of someone who perceives herself as a failure. These are the last two reasons not to change. They are the avoidance of what one client of mine called "*destroying the negatives*" and the maintenance of what I call *"conditional aloneness in the presence of others."*

Reason Nine: Destroying the negatives

In therapy, one remembers the past in the truest sense of the word. We re-member our history leading up to our present predicament, re-collecting what previously felt like disconnected shards of the past. The remembering and recollecting is conducted

with others. In this sense, therapy is often an act of *co*mmemorating: One's past – and the meaning of one's past – is shared and shaped in a relationship. In this light, therapy serves as a kind of memorial, in which the reality of past experiences is finally witnessed by another. By giving form to events from the past, one is able to finally put them to rest. Yet therapy also lacks an ingredient found in most memorials: Therapy is all language, emotion, reflection, relationship. No tangible artifact emerges from the commemoration of therapy. Nothing is set in stone.

Memorials are supposed to endure as monuments to memory, as concrete sites where memory is made immortal, and as solid, heavy counters to the fleeting lightness of memory. That's why they are made of stone. Therapy, while an act of commemorating, lacks the durability of a real memorial. In therapy, there is no urn for the ashes of one's past. Therapy keeps the past, and our memories of the past, articulated and formed, but uncontained. As well it should. One will get nowhere in therapy if it is merely a monument to grievances, or a site where one only mourns a difficult past.

For someone overwhelmed by disappointment and a sense of failure, the need for others to recognize past damage is often insatiable. For this person, the therapist's recognition of her difficult history is not only empathetic, but a means to a life-story imbued with themes of external forces and individual passivity. This person is looking for a solid, enduring memorial that diminishes the expectations of others by locating an unimpeachable cause of his passivity. For him, the greatest threat to this memorial is change. Acting independently threatens him because exposing his agency to others could signal that the past was not as bad as he has portrayed it.

As one of my clients described it, change is "like destroying the negatives" of her past (a remarkable term, as it can mean both destroying the memory of negative experiences and, symbolically, destroying the photographic record that they occurred). Becoming better, for her, meant partially obliterating the proof of her hardships. There is a real logic to this way of thinking: If a person does well, this might mean that past events, while painful and even traumatic, were not so oppressive as to ruin his ability to survive – and to change in a positive way. *Keeping his behavior the same is thus his only means of protecting an enduring memorial to the past. Changing this behavior is like demolishing his memorial.*

I once had a client who ingeniously found a way to change for the better without destroying the negatives. I was assigned a group for people with mood disorders in a day treatment program. In the group, I used a well-worn way of checking on each member's mood (a classic technique that I rather dislike today, but felt compelled to use back then). Each week, I would ask members to rate their mood on a scale from one to ten: one being utterly disabling depression, and ten being no depression. Each week, a woman I'll call Nancy would report her mood as a "two." Nancy had experienced an awful couple of years: Her husband left her for another woman, she lost her job and her house, and her adult children would not speak to her, siding with her ex-husband and spending holidays with him, while she was left alone. However, though she would report a "two" each week, I secretly knew a different story. I was the case manager for a couple of other women in the program. Both these women attended church with Nancy. Both reported remarkable changes in her behavior, things she didn't tell us in group. "Nancy's running the coffee hour after services;" "Nancy asked us to help her decorate her new apartment;"

"Nancy spoke in church today;" "Nancy got a job;" "Nancy's dating someone from church." Nancy was clearly improving. But in group, she always said "two." Finally, Nancy just stopped showing up. She never returned. But I heard about her from my confidants: Nancy kept improving.

My guess is that Nancy's narrative of depression and dysfunction was her only evidence of the wrongs done to her. If she improved, she would deviate from her role as a patient and erase this evidence. If she stayed a "two," she could assure herself that others would witness the pain imposed on her. Yet staying this way would also lead to a confined and rather meaningless life. So what did Nancy do? She retained her therapy group as a monument to her pain, while improving in her daily life. Unaware of my "spies," she ended treatment feeling she had left behind a permanent memorial to her pain. Smart move.

Reason 10. Conditional aloneness in the presence of others

If you are a parent, you will know this phenomenon: Your child is in another room playing by herself. You can hear her in there, alone, talking, singing, making noises. She seems so focused on play, so separate from your presence in the other room. Then the phone rings. You answer it. All of a sudden, she is by your side. You try to stay on the phone, to concentrate on what the other person is saying, but all you hear is, "Dad. Dad. Dad. Dad. Dad. Dad……." At this point, you may realize that your child was never truly playing alone. All along, your presence facilitated her playing. She was able to be alone because she knew you were only a room away, hearing her, thinking about her. She was, as D.W. Winnicott succinctly puts it, "alone in the presence of

other." Her ability to be alone, and to be able to play and imagine, was actually dependent on her sense that she was "held" somehow, in your mind. The phone call broke the spell of your presence, and thus damaged her ability to be "alone."

To approach life securely, adults also need this sense that someone is thinking about them; that they exist in the consciousness of someone else; that, while alone, they are vital to others. When we know we are held in the consciousness of another, we may be playing or working alone, but our aloneness is less stark, less *lonely*.

When we are seen in this manner, we are also typically seen and appreciated for our actions, our agency, and thus our accountability. For someone overwhelmed by guilt and disappointment, who views herself as a failure, being seen by others in this manner feels dangerous. This person needs to feel held within the gaze of another, yet without too much expectation about her accountability. She wants to be gazed upon, but seen as passive. She actively seeks recognition, but she does so under the condition that the person recognizing her does not detect her authorship. I call this position towards recognition "conditional aloneness in the presence of others." It's another bargain struck by someone who enters the patient role: a means to attain an important social resource while avoiding exposing her agency.

Therapy, and especially, therapeutic communities, offer this balance between continuous attention and low expectations about agency. In fact, such communities exert a lot of energy in looking and gazing. With their patient charts, their tendency to "begin where we left off," their propensity to remember and remark on the progress of each client's life, they pay attention to individuals in a continuous, unbroken manner. *Therapists and therapeutic communities offer enduring recognition to those they treat,*

providing their clients the important sense that they exist in the mind's eyes of someone else even when they are out of physical sight. And they often provide this continuous attention without the pressures of expectations regarding accountability.

The earlier example of Hillary is a case in point. Hillary wanted clinicians to call her for "check-ins." She preferred receiving these scheduled calls rather than contacting our on-call clinician at any time. For Hillary, scheduled calls meant we were remembering her. By scheduling a call, Hillary would know she was on someone's mind. For many hours, the on-call clinician had to remember to call her at the appointed time. Once this call was finished, the next on-call clinician would take up the baton of attention and remembrance, scheduling the next day's call. The relay in memory and attention could continue *ad infinitum*. The scheduled calls achieved two things for Hillary: They kept Hillary in our minds, and they kept her held in this way with a minimum of focus on her as an active agent. If we participated in Hillary's plan, we would be remembering only to make calls at a certain point in the day. We *wouldn't* be remembering Hillary because of our pride in her, or our thoughts about her skills and aptitudes. Our gazing would be rote, predictable, and without expectations.

Hillary was seeking a balance between being remembered and avoiding accountability in a more subtle way than she previously had. Her request for scheduled calls represented a positive change for her. For over twenty years, Hillary regularly presented to clinicians as suicidal. She superficially cut herself, then immediately asked for help. This process of "parasuicidality" (an apparent attempt at suicide in which the goal is not death) would bring instant attention from clinicians. And they would remain attentive to her long after they left work, as they went on with their days feeling anxious

about Hillary's safety. It thus had the effect of ensuring that the attention was continuous. At the same time, her parasuicidality operated as a sort of caution to clinicians that they must not raise issues of accountability. They were afraid to treat Hillary as an accountable actor because they were concerned this would only lead to more risky behavior. In fact, if you were to trace the times Hillary cut herself, you would likely find that she engaged in these behaviors following moments when she confronted her accountability. She might become parasuicidal after someone noticed significant positive change in her life, or when she felt unable to achieve a goal she had set for herself. She would cut herself when she felt others were becoming complacent, not recognizing the pain in her history, or when she couldn't stand the expectation that she would need to take small steps to move forward. Whatever the obstacle she confronted, parasuicidality was her way to reduce expectations while remaining in the continuous gaze of others.

Over time, Hillary made the courageous move to disengage from the rather effective behavior of parasuicidality. However, she still wanted to engage in interactions in which she was seen by others, but only seen as inert. The request for scheduled calls was a gentle, less violent means to reach this solution. Like all of us, Hillary needed to feel as if she were held within another's consciousness, even when that other was not around. Yet she could only bear this kind of attention if it was struck in a bargain for low expectations about her accountability.

The Ten Reasons Not To Change show a powerful relationship between changing and staying the same. We all face the tension between these two forces. However, for someone traumatized by repeated disappointment, the tension never lets up and the allure

of stasis can be the stronger. Meanwhile, this person's life as a psychiatric patient is marked by issues of change: getting better, regressing, improving, recovering. Thus, the issue of change, and the pressure to change, are forever on their mind. Feeling this pressure, and worried about the consequences of attempting change, a person might see sameness and refusal to change as their only sanctuary.

Change and its Inevitable Paradox

Not changing is a legitimate and time-tested means for gaining immediate security. It is not, however, the best means for building an autonomous, well-connected and purposeful life. That's the difficult paradox of change. No matter which side one takes – change or refusal to change -- one is at risk. Choosing change, one risks the crushing blow of disappointment. Choosing to stay the same, one risks the dulling loss of meaning and connection to others that comes with sameness. Considering these risks, we all might want to exile a certain word in our vocabulary when we talk about change: "just." "Just do it!" "Just say no!" "Just pull yourself up by your bootstraps," "Just take the leap." If only change were *just* that simple. But it's not.

Personal change is always a courageous act. When someone resists change, it is because the challenge before them requires more courage than they can muster. It is not, however, evidence of cowardice. Instead, it is a measure of the challenge the person confronts. We make a grave mistake when we see this challenge as merely the act of making the change the person desires in their life. (I'm confident I have the skills to clean my office!) The real challenge is the difficulty of hoping in the face of potential disappointment. Each disappointment in a person's life leaves sediment on an

increasingly steep slope of risk, and a weight on their back that only hope can lift. For someone who has experienced repeated failures, the slope of disappointment and the weight of lost hope can become global, affecting their attempts at a diverse array of tasks. This is especially true for someone who has been diagnosed and treated for a mental illness. They are recipients of clear messages that they are damaged, and they are veterans of the trauma of multiple setbacks in their quest to fix this damage. For them, every act of change risks another message of brokenness, and thus portends another fall into the ever-deepening experience of failure.