RELENTLESS HOPE

THE REFUSAL TO GRIEVE

Martha Stark MD

RELENTLESS HOPE:

The Refusal to Grieve

Martha Stark, MD

Created in the United States of America

Table of Contents

PREFACE

INTRODUCTION

SADOMASOCHISM

A RELATIONAL APPROACH TO SADOMASOCHISM

ENHANCEMENT OF KNOWLEDGE

Model 1—Rendering the Defense Less Adaptive

ENGAGEMENT IN AUTHENTIC RELATIONSHIP

Model 3—Rendering the Defense Less Toxic

PROVISION OF CORRECTIVE EXPERIENCE

Model 2—Rendering the Defense Less Necessary

CONCLUSION

ADDENDUM

REFERENCES

PREFACE

Many a patient, as a child, has suffered great heartache at the hands of a misguided, even if well-intentioned, parent, be it in the form of psychological trauma and abuse (too much bad) or emotional deprivation and neglect (not enough good). Such a patient may never have had occasion to confront the pain of her grief about the parent's unwitting but devastating betrayal of her. Instead, she has defended herself against the pain of her heartache by pushing it, unprocessed, out of her awareness and clinging instead to the illusion of her parent (or a stand-in for her parent) as good and as ultimately forthcoming if she (the patient) could but get it right.

Under the sway of her repetition compulsion, the patient—as she struggles through her life—will find herself delivering into each new relationship her desperate hope that perhaps this time, were she to be but good enough, want it badly enough, or suffer deeply enough, she might yet be able to transform this new object of her relentless desire into the perfect parent she should have had as a child—but never did (Stark 1994a, 1994b, 1999, 2015).

As long as the patient continues her relentless pursuits, however, and refuses to come to terms with the reality of the limitations, separateness, and immutability of the people in her world—and the limits of her power to make them change—then she will be consigning herself to a lifetime of chronic frustration, heartache, and unremitting feelings of impotent rage and profound despair.

Elvin Semrad (Rako 1983) captures this poignantly with the following: “Pretending that <something> can be when it can’t is how people break their heart.”

If the patient is ever to relinquish her passionate but self-sabotaging pursuits, then she must someday dare to let herself first remember the outrage and the anguish of just how heartbreaking it really was—both the parental errors of commission (presence of bad) and the parental errors of omission (absence of good)—and then confront the pain of her disillusionment in the parent, grief against which she has spent a lifetime unconsciously defending herself.

Only once the patient has been able to master and integrate the dissociated grief will she be able to relinquish her relentless and infantile pursuit of the unattainable. She will have transformed dysfunctional defense (the need to hold on) into more functional adaptation (the capacity to let go) once she has grieved and, in the process, developed a more refined awareness of the limitations inherent in relationship and a more evolved capacity to accept that which she cannot change.

The bad news will be the sadness the patient experiences as she begins to accept the sobering reality that disappointment is an inevitable and necessary aspect of relationship. The good news, however, will be the wisdom she acquires as she comes to appreciate ever more profoundly the subtleties and nuances of relationship and begins to make her peace with the harsh reality of life's many challenges.

The title of this book is *Relentless Hope: The Refusal to Grieve*. An alternative title, however, could have been *Transformation of Relentless Hope: A Relational Approach to Sadomasochism*. At the end of the day and as will become clear in what follows, relentless hope is ultimately a story about the patient's masochism (here defined as a willingness to suffer if doing so will enable the patient to maintain her hope); and relentless outrage is ultimately a story about the patient's sadism (here defined as the patient's rageful and retaliatory reaction to having been thwarted in her desire).

Masochism and sadism are not being used to describe what gets played out in the sexual

arena; rather, the terms are being used to describe the dysfunctional relational dynamic that gets played out, to a greater or lesser extent, in most of the patient's intimate relationships when early-on heartbreak (in relation to the parental object) is never fully processed, integrated, and adapted to and is instead defended against.

It will then be within the context of safety provided by the relationship with her therapist that the patient will be able, at last, to do what she never had an opportunity to do in her early years, namely, to confront, grieve, and make her peace with the reality of the devastating disillusionment that she experienced at the hands of a parent who broke her heart.

My hope is that this slender volume will prove to be clinically—and, perhaps, personally—useful to all my readers. Thank you for taking the time…

I dedicate my book to all the patients with whom I have worked and collaborated over the course of my career—people whom I have loved and from whom I have learned so much.

INTRODUCTION

Relentless hope is a defense to which the patient clings in order not to have to feel the pain of her disappointment in the object, the hope a defense ultimately against grieving. The patient's refusal to deal with the pain of her grief about the object (be it the infantile, a contemporary, or the transference object) fuels the relentlessness with which she pursues it, both the relentlessness of her hope that she might yet be able to make the object over into what she would want it to be and the relentlessness of her outrage in those moments of dawning recognition that, despite her best efforts and most fervent desire, she might never be able to make that actually happen.

What fuels the patient's relentlessness (both her relentless hope and her relentless outrage) is her inability to sit with the pain of her disappointment in the object—an object she experiences as bad by virtue of its failure to live up to her expectations.

But, even more fundamentally, what fuels the relentlessness of the patient's pursuit is the fact of the object's existence as separate from hers, as outside the sphere of her omnipotence, and as therefore unable to be either possessed or controlled. In truth, it is this very immutability of the object—the fact that the object cannot be forced to change—that provides the propulsive fuel for the patient's relentless pursuit.

Ironically, such patients are never relentless in their pursuit of good objects. Rather, their relentless pursuit is of the bad object. In other words, it is never enough that the patient simply find a new good object to compensate for how bad the old object had been. Rather, the

compelling need becomes, first, to create or, more accurately, to recreate the old bad object—the comfort of the *familial and therefore familiar* (Mitchell 1988)—and, then, to pressure, manipulate, prod, force, coerce this old bad object to change.

A song that speaks directly to this issue of the patient's need to recreate the early-on traumatic failure situation is a rock song by the late Warren Zevon (2008) entitled "If You Won't Leave Me I'll Find Somebody Who Will." The patient can refind the old bad object in any one of three ways: (1) she can choose a good object and then experience it as bad (projection); (2) she can choose a good object and then exert pressure on it to become bad (projective identification); or (3) she can choose a bad object.

Again, choosing a good object is not an option. A good object does not satisfy. Rather, the need (fueled by the patient's repetition compulsion) is to re-encounter the old bad object—and then to compel this bad object to become good. It is this that satisfies.

By way of brief example: A woman who suffered terribly at the hands of an alcoholic parent will not simply resolve to choose a partner who does not drink. Rather, she will find herself choosing as her mate an alcoholic. She will then focus her relentless efforts first on forcing him to own the fact of his alcoholism and then on forcing him to give it up—although he might well never do this and a panel of 10,000 objective judges would probably have been able to predict that.

More generally, had the relentless patient (as a very young child) had the experience, at least for a while, of having her every need recognized and responded to by a parent who could have allowed herself to be possessed and controlled, by a parent who could have allowed herself to be shaped by her child's evolving relational needs, then the patient would now (as an adult) have much greater a capacity to tolerate the separateness of her objects and much less urgent a need to pursue them relentlessly in an effort to *make* them change.

Winnicott and the Good-Enough Mother

It is to Winnicott (1965) that we owe our understanding of, and appreciation for, the very young child's healthy need to possess and control her objects, an age-appropriate need that the mother must, at least initially, gratify if her child is ever to move successfully beyond this early stage in her development. Writes Winnicott, a mother who is *good-enough* will be so exquisitely attuned to her infant's every gesture that the mother will be able, again and again, to meet the omnipotence of her infant, thereby reinforcing its sense of personal agency. Then, as the child develops, the child will be better equipped to relinquish her need for omnipotent control of her objects and more ready to transform that infantile need into the mature capacity to derive pleasure from controlling not her objects but her own life.

A mother who is not good-enough, however, will be unable to satisfy her infant's developmental need to have complete and absolute control of her surrounds. As a result, the child will not outgrow this need; rather, the child, as she grows older, will be unable and unwilling to relinquish her illusions of omnipotent control of her objects. The thwarted need will become reinforced over time and ever more charged, ultimately manifesting as a compelling drive to possess and control the objects in her world and, when she is confronted with the limits to her imagined omnipotence by their refusal to relent, an equally compelling drive to retaliate by attempting destruction of them.

Fairbairn and the Seductive Object

And it is to Fairbairn (1954) that we owe our understanding of, and appreciation for, yet another aspect of the patient's intense attachment to the bad object, namely, her ambivalence. The bad object is a seductive object that initially excites but ultimately rejects. The patient's *libidinal ego* will attach itself to the exciting object and long for contact, hoping against hope that the object will deliver. The patient's *antilibidinal (or aggressive) ego*—a repository for all the

hatred and destructiveness that have accumulated as a result of frustrated longing—will attach itself to the rejecting object and rage against it. In other words, the patient will have an intensely conflicted, highly ambivalent relationship with the bad object—a seductive object to which she is both libidinally and aggressively attached, an exciting / rejecting object that she both needs (because it excites) and hates (because it rejects).

In essence, the patient's relentless pursuit is of an object that will initially tantalize by offering the seductive promise of a certain kind of relatedness but later devastate by rescinding that enticement.

A Protracted Grieving Process

Growing up (the task of the child) and getting better (the task of the patient) have to do with mastering the disappointment and pain that come with the recognition of just how limited, just how unreliable, and, ultimately, just how separate, immutable, and unrelenting one's objects (both past and present) really are—a protracted grieving process that involves confronting, and eventually coming to terms with, the sobering reality that ultimately one has no real control over one's objects. One has no real control because those objects are separate and cannot be possessed, although they are compellingly appealing by virtue of their enticing seductiveness.

As will later be demonstrated, the therapeutic process must be able to facilitate relinquishment of the patient's relentless pursuit and transformation of her infantile need to possess and control her objects and, when thwarted, her infantile need to attempt destruction of them into the mature capacity to relent, to accept, to grieve, to forgive, to internalize whatever good there was, to separate, to let go, and to move on. In essence, the therapeutic action will make possible transformation of the patient's relentless hope and, when thwarted, her relentless outrage into the healthy capacity to accept the reality that her objects will never be all that she would have wanted them to be.

SADOMASOCHISM

The patient's relentless pursuit of the bad object has both masochistic and sadistic components: The patient's relentless hope (which fuels her masochism) is the stance to which she desperately clings in order to avoid confronting certain intolerably painful realities about the object of her desire and its limitations; and her relentless outrage (which fuels her sadism) is the stance to which she resorts in those moments of dawning recognition that the object is separate, has its own center of initiative, and is not going to relent.

Masochism and sadism always go hand in hand, although the patient may appear to be, simply, masochistic. Furthermore, masochistic hope and sadistic rage are flip sides of the same coin; they are both defenses and speak to the patient's refusal to confront the pain of her grief about the object's refusal to be possessed and controlled, the object's refusal, ultimately, to allow itself to be shaped by the patient's need for the good parent she never had reliably and consistently early-on.

Parenthetically, the concept of sadomasochism is not here being used to describe what happens in the sexual arena; rather, it is here being used to describe the dysfunctional relational dynamic that gets played out, to a greater or lesser extent, in most of one's intimate relationships.

The Masochistic Defense of Relentless Hope

More specifically, masochism is a story about the patient's hope, her relentless hope, mobilized as a reaction to the intolerable pain she experiences in the face of the object's refusal

to be all that she would have wanted it to be—her hoping against hope that perhaps someday, somehow, someway, were she to be but good enough, try hard enough, be persuasive enough, persist long enough, suffer deeply enough, or be *masochistic* enough, she might yet be able to extract from the object of her desire (sometimes the parent herself, sometimes a stand-in for the parent) the recognition and love denied her as a child—in other words, that she might yet be able to compel the immutable object to relent. The intensity of this pursuit is fueled by her conviction that the object could give it (were the object but willing), should give it (because that is the patient's due), and would give it (were she, the patient, but able to get it right).

Please note that the patient's investment is not so much in the suffering per se as it is in her passionate hope that, perhaps, this time...

The Sadistic Defense of Relentless Outrage

Sadism is the reaction of the relentless patient to disappointment. The healthy response to disillusionment is to confront and grieve it, feeling all that needs to be felt in order ultimately to come to terms with the reality of it. But a patient who is relentless cannot tolerate the pain of her disappointment; instead, she feels helpless, hopeless, and despairing.

Please note that patients whose plaintive cry is of feeling helpless and hopeless are often merely describing their reaction to being unable to force their objects to change.

With the patient's dawning recognition that she is not going to get her way after all and fueled by her conviction that she has been betrayed, wronged, or even victimized, she will react with the unleashing of a torrent of abuse—whether in fact or in fantasy—directed either toward herself (for having failed to get what she had so desperately wanted) or toward the disappointing object (for having failed to deliver).

The unleashing of her abusiveness is powered by her belief that she either has no choice but to lash out against the object (because it has victimized her) or is entitled to lash out against the object (because it is now her turn to victimize).

The Sadomasochistic Dance

In any event, this sadomasochistic cycle is repeated once the seductive object throws the patient a few crumbs. The patient, ever hungry for such morsels, will become once again hooked and revert to her original stance of suffering, sacrifice, and surrender in a repeat attempt to get what she so desperately craves and feels she must have in order to survive.

How Have I Failed You?

So if the patient (during a therapy session) becomes abusive, what question might the therapist think to pose?

If the therapist simply asks the patient "How do you feel that I have failed you?" at least she knows enough to have asked the question; but she is also indirectly suggesting that the answer will be primarily a story about the patient (and the patient's *perception* of having been failed).

It is therefore better that the therapist ask "How have I failed you?" Now she is signaling her recognition of the fact that she herself might well have contributed to the patient's experience of disillusionment and heartache, perhaps, say, (1) by not fulfilling an implicit promise earlier made, (2) by refusing to acknowledge her unrelenting commitment to a particular perspective, (3) by failing to admit to a mistake or error in judgment, (4) by denying her contribution to a therapeutic impasse, or (5) by no longer being willing to do something that she had once been willing to do. The therapist must have both the wisdom to recognize and the

integrity to acknowledge (certainly to herself and perhaps to the patient as well) the part she might well have played by first stoking the flames of the patient's desire and then devastating through her ultimate failure to deliver.

Internal vs. Relational Sadomasochism

To this point, the focus has been on the way in which sadomasochism manifests itself relationally; and Fairbairn (1954) was used to explain the underlying endopsychic situation, namely, that the patient has both an intensely libidinal and an intensely aggressive attachment to the bad object (thus the ambivalence of her attachment and the relentlessness of her pursuit). These same patients will often have both an intensely libidinal and an intensely aggressive attachment to the bad self, manifesting as self-indulgence on the one hand and self-destructiveness on the other. Whereas both the patient and her partner will suffer when the patient's sadomasochism is played out relationally, for the most part only the patient suffers when it is played out internally.

As an example of this latter, consider an eating disordered patient whose eating binges (gratification of libido) alternate with episodes of fasting (gratification of aggression). The vicious cycle will then go as follows: The patient, feeling deprived, becomes resentful and then feels entitled to gratification by indulgence in compulsive eating, which then makes her feel guilty and anxious and prompts her to punish herself by severely restricting her caloric intake, which then makes her feel (once again) deprived, angry, and entitled to indulge in yet another eating binge, and so on and so forth. Deprivation, self-indulgence, guilt, self-destructiveness.

In other words, sadomasochism can be played out either relationally (in the form of alternating cycles of relentless hope and relentless outrage) or internally (in the form of alternating cycles of self-indulgence and self-destructiveness)—although here the focus will be on the enactment of sadomasochism relationally.

A RELATIONAL APPROACH TO SADOMASOCHISM

Addressing now the issue of how a patient's relentlessness can be tamed, modified, and integrated into the healthy capacity to relent, accept, forgive, internalize, let go, and move on. It is certainly a daunting task for any therapist who dares to confront the patient's sadomasochism—but it is also an extraordinary gift that we can offer if we but have the ability and the willingness to negotiate at the *intimate edge* (Ehrenberg 1992) of relentless relatedness with a patient who may know of no other way to engage. To be truly effective, we must have first the capacity to tolerate being made bad (which heralds the induction phase of a projective identification) and then the capacity to relent (which ushers in its resolution)—in the process both confronting the patient with the fact of her relentlessness and confronting the reality of our own.

Knowledge, Experience, and Relationship

Elsewhere (Stark, 1994a, 1994b, 1999, 2015a), three modes of therapeutic action have been described.

Model 1—enhancement of knowledge *within* (the interpretive perspective of classical psychoanalytic theory);

Model 2—provision of corrective experience *for* (the deficiency-compensation perspective of self psychology and those object relations theories—like Michael Balint's—that emphasize the *absence of good*); and

Model 3—engagement in authentic relationship *with* (the intersubjective perspective of contemporary relational theory and those object relations theories—like Fairbairn's—that emphasize the *presence of bad*).

The most effective approach to dealing with the patient's relentlessness (both her masochistic defense of relentless desire and her sadistic defense of relentless vengefulness) will be one that draws upon all three modes of therapeutic action.

Relentlessness as a Self-Protective Defense

But, first, it must be deeply appreciated that the patient's relentlessness is a defense—a defense against grieving, a defense against confronting the intolerably painful reality of the object as not only disappointing but intractably and unrelentingly so.

Point of clarification: When a disappointment is experienced as painful, but tolerably so, it can ultimately be processed and mastered. But when it is experienced as too painful, as intolerably painful, then the disappointment cannot be grieved and must instead be defended against. Painful can be managed and may even promote psychic growth; but too painful (too uncomfortable, too anxiety-provoking) is unmanageable and prompts mobilization of defenses.

Both the patient's relentless hope and her relentless outrage speak, then, to the operation of the patient's defenses; both the masochistic defense of relentless hope and the sadistic defense of relentless outrage are fundamentally self-protective reactions to intolerably painful truths about the object's limitations, separateness, and refusal to relent.

As with all defenses, before the patient's relentlessness can be relinquished, it must be rendered *less adaptive* (the province of Model 1), *less necessary* (the province of Model 2), and *less toxic* (the province of Model 3).

Clinical Vignette: My Unforgivable Mistake

In order to demonstrate the translation of theory into practice, I will present my work with Sara, a woman with whom I worked intensively for many years, seeing her as often as four to five times a week. But, at the very beginning of our work, I had made an "unforgivable" mistake, which made her feel she would never be able to trust me.

Over the course of our many years together, despite much good work that we did, Sara's need became to force me to admit not only that I had made a mistake (which I was easily enough able to do) but that the mistake I had made was unforgivable (which I was not able to do). What made the situation particularly tormenting for me was the fact that Sara was relentless in her efforts to get me to confirm her perception of me as having failed her unforgivably early-on in our work and very clear that were I to confirm that perception, then she would have no choice but to terminate her work with me. On the other hand, when I did not agree with her that my mistake had been unforgivable, then she felt she had no choice but to continue to experience me as untrustworthy and to torment me for being so.

Over time, what Sara and I came to appreciate about our dynamic was that we had unwittingly recreated between us the powerfully torturing relationship that she had long had with her toxic mother. At times, Sara was in the role of her bad mother and it was I who was in the role of Sara, the little girl tormented by her double-binding mother; at other times, I was in the role of her bad mother and it was Sara who was tormented by me as she had once been tormented by her mother.

Our understanding of the co-created sadomasochistic dynamic that was being replayed between us was actually helpful to us both and enabled us to stay in the relationship; but it was not enough to get us out of the mutually tormenting Catch-22 situation that was being re-enacted between us. It was not enough until one day, in reaction to yet another demand from Sara that I

acknowledge the unforgiveableness of my mistake those years earlier, I found myself, as I listened, feeling suddenly so sad, so trapped, so anguished, and so tormented that I suddenly burst into tears, resting my head in my hands and just sobbing—Sara, meanwhile, sitting there very still, barely breathing, just watching, waiting, saying nothing.

But later in the session, I believe that she showed me what it must have been like for her—she herself began to cry, putting her head in her hands and weeping, while I now sat there very still, barely breathing, watching, waiting. Particularly poignant for me was my knowing that Sara (as an adult) had never before cried in front of anyone.

As it turned out, this was a turning point in the treatment and, although Sara later took a several-year break because her husband's job required that they relocate to California, she eventually returned to Massachusetts (in large part to complete her treatment with me) and, after an investment of several more years, we did ultimately finish our work—both of us, by then, deeply satisfied with all that we had accomplished along the way, and both of us much, much richer and wiser for the experience of having loved and hated each other so intensely over the course of our intimate journey together.

Accountability and the Capacity to Relent

Although in any treatment all three modes of therapeutic action (enhancement of knowledge, provision of experience, and engagement in relationship) operate simultaneously, I will here be presenting my work with Sara from the perspective –

First, of Model 1, Sara's taking ownership of, and gaining insight into, her underlying sadomasochistic dynamics and the price she was paying for being so relentless;

Then, of Model 3, our negotiation at the intimate edge of sadomasochistic engagement and

ultimately resolving the mutual enactment being played out between us; and,

Finally, of Model 2, Sara's relenting, confronting at last the pain of her grief about her devastatingly disappointing objects, and forgiving them their limitations, separateness, immutability, and seductiveness.

In other words, in Model 1, the therapeutic action involved Sara's accountability for her relentlessness; in Model 3, the therapeutic action involved my accountability for my relentlessness and, ultimately, my capacity to relent; and, in Model 2, the therapeutic action involved Sara's capacity to relent. More generally, in working through the patient's relentlessness, both patient and therapist must take responsibility for their relentlessness and must be able, ultimately, to relent. Accountability and the capacity to relent are where the therapeutic action lies.

ENHANCEMENT OF KNOWLEDGE

Model 1—Rendering the Defense Less Adaptive

Ordinarily, a classically trained, interpretive therapist strives to maintain her neutrality and objectivity. But when working with a patient's relentlessness, it behooves the therapist to assume a more vigorously interpretive stance, resorting even to bold challenge and direct confrontation if necessary. The therapist's intent is to highlight the issue of the patient's accountability (the patient as agent), that is, the patient's taking of responsibility for her refusal to relent and its dire consequences.

In other words, the therapist relinquishes her customary stance in favor of one that involves the use of her more critical faculties, even (when appropriate) articulating the very real shock and horror she finds herself experiencing in the face of the patient's self-indulgent and self-destructive relentlessness.

The therapist, of course, must avoid becoming moralistic or judgmental. It is a fine line, to be sure, this distinction between a tough-minded, no-nonsense, reality-based ego stance and a harshly punitive, morality-based superego stance—but a line that the therapist must be able both to understand and to honor. The therapist's aim is to access the patient's observing ego and self-reflective faculties and to enhance the patient's understanding of her relentlessness and its costliness to her; and the therapist's hope is that, over time, the patient will be able to access her own shock and horror—that anyone, no matter how desperate, tormented, or enraged, would be this relentlessly indulgent and destructive.

The Model 1 therapist must also be attuned to the level of the patient's anxiety so that she can regulate it—confronting (when she senses the patient can tolerate being challenged) but, all the while, appreciating that if the patient's anxiety becomes too great, then the patient might well react with an intensification of her defensive efforts and a reinforcement of her relentlessness.

Additionally, the therapist must be mindful of the fact that there is ever tension within the patient between her capacity to take responsibility for her actions and her need to deny such responsibility, her healthy capacity to be held accountable for her behavior and her defensive need to avoid such accountability.

Masochism and Sadism Statements

I have developed two therapeutic interventions, a *masochism statement* and a *sadism statement*—interventions specifically designed to enhance the patient's knowledge of how she enacts her sadomasochism in her relationships (Stark 1994a, 1994b).

The format of a masochism statement is as follows:

Although you know the disillusioning reality that… / it hurts too much to sit with the pain of it and so you keep hoping… (and feel entitled…)

To Sara, I would say things like—

"Even though you know that you will someday need to make your peace with just how disappointed and angry you are with your mother, in the moment, even the thought of having to do that is absolutely intolerable. And so a part of you keeps hoping that maybe someday things will simply get better without your having to do anything."

“Although, at least on some level, you know that your mother will never be willing or able to acknowledge just how mean and insensitive she can be, you find yourself desperately wishing that she could and feeling that this is the least of what she now owes you.”

"On some level, you know that your husband will never be emotionally available in the ways that you would have wanted him to be. But it makes you too sad to think about all that right now. So you keep hoping and, periodically, find yourself pressuring him to try just a little harder."

"Although you know that you pay a high price for demanding that your husband be more responsive and that you are setting yourself up to be continuously hurt and disappointed, you tell yourself that it doesn't seem that unreasonable to be expecting your husband simply to ask you how your day went when he comes home from work at night."

The format of a sadism statement is as follows:

When you feel misunderstood, betrayed, wronged… / it hurts and angers you so much that you feel you have no choice but to lash back… (you feel entitled to lash back…)

To Sara, I would say things like –

"When you think about how much I hurt you when I said what I did in our third session those years ago, it makes you feel so awful that you don't quite know what to do with your upset, your pain, and your anger. I think there's also a part of you that feels such outrage that you then feel justified in trying to hurt me back."

“When I broke your heart with my insensitivity, you found yourself feeling so desperate and so defeated that a part of you simply stopped caring about anything.”

"Whenever your mother breaks your heart by promising you something and then later forgetting about it, the experience of that betrayal is so devastating that, for a while, you become immobilized and can barely get out of bed in morning."

"When you're confronted with yet another instance of your mother's cruelty, you find yourself so overwhelmed with feelings of helplessness and impotent rage that you begin to lash out at everything and everybody around you."

"When you feel you've been wronged, you can get pretty ugly if you have to."

Gain vs. Pain

As with all defenses, the patient must eventually come to recognize that she is relentless (with respect to both her hope and, when thwarted, her outrage) and that the sadomasochistic way in which she engages her objects is a self-protective choice she has made in order to avoid the pain of her heartrending grief about their limitations, their separateness, and their immutability.

By way of a series of no-nonsense masochism and sadism statements that contextualize the patient's relentlessness as a story about her inability to sit with the pain of her grief, the therapist will hope to illuminate the patient's investment in having the defense, how it has served her, how it has benefited her, and how adaptive it has been and therefore ego-syntonic—in other words, the *gain*. At the same time, the therapist will hope eventually to expose just how great a price the patient has paid for holding on to the defense, how costly it has become, and how maladaptive and therefore ego-dystonic it now is—in other words, the *pain*. Sara was indeed able ultimately to take ownership of her relentlessness—to understand both the gain (the benefit) and the pain (the cost).

As long as the gain is greater than the pain, the patient will maintain the defense and remain entrenched. But as the patient gets ever more in touch with the price she is paying for refusing to relent, the defense will become more and more ego-dystonic.

And once the pain becomes greater than the gain, the stress and strain thereby created will then provide the impetus for the patient's ultimate surrender of the defense. In essence, as the patient comes increasingly to appreciate the high price she has paid for clinging to her relentlessness, the defense will become less and less adaptive and the anxiety and tension thereby created will then provide the therapeutic leverage needed for the patient to relent.

In essence, in Model 1, by way of a series of masochism and sadism statements that force the patient to take ownership of her sadomasochism and the price she has been paying for being so relentless, the defense of relentlessness will be rendered less adaptive.

ENGAGEMENT IN AUTHENTIC RELATIONSHIP

Model 3—Rendering the Defense Less Toxic

As noted earlier, the relentless patient (under the sway of her repetition compulsion) will have a need to re-encounter the old bad—unrelenting—object, the unhealthy piece of which will have to do with the comfort of the familiar but the healthy piece of which will have to do with the need to achieve belated mastery, the hope being that perhaps this time there will be a different outcome, a better resolution.

So, as patient and therapist navigate the turbulent waters generated by their engagement at the intimate edge of their relentless relatedness, the therapist will inevitably find herself impacted by the force field created by the patient's need to be now failed as she was once failed. In other words, the therapist will find herself unwittingly drawn in to participating in the patient's re-enactments as an intractably bad object—a transference / countertransference entanglement that is necessary if the relentless patient is ever to rework the original traumatic failure situation.

The Therapist's Capacity to Relent

The sadomasochistic dance that ensues between patient and therapist will be tormenting for both and may last for weeks, months, or years—until somebody does something. Again, even if the problem lies in the intersubjective space between patient and therapist, with contributions from both, it is crucial that the therapist have the adaptive capacity to relent—and to do it first.

Indeed, if there is to be resolution of their stalemated, gridlocked *crunch* situation (Russell 1980), then what the therapist must be able to do is to relent, to give in, and to let go, on behalf of a patient who truly does not know how.

What exactly does it mean to *relent*? I am here reminded of the story about a judge who, when asked to define pornography, said simply "You know it when you see it."

But the therapist's capacity to relent might take the form of being able to let go of her need to be right, to win, or to have her own way. Alternatively, it might take the form of being able to relinquish her need to make the patient better, gain insight, experience more affect, or deliver more of herself into the relationship. Finally, the therapist's relenting might take the form of admitting to a mistake, backing off from an unrelenting commitment to a particular perspective, admitting to having been, say, not just angry but inappropriately angry, acknowledging unwitting seductiveness, admitting to relentlessness, offering the patient a heartfelt apology, or, as happened in my work with Sara, exposing my own raw vulnerability and desperation in the form of my tears.

Most difficult of all, perhaps, is when the patient demands that the therapist relent by acknowledging the contribution of the therapist's own unresolved neurotic issues or, even, underlying character pathology to the messiness that has unfolded between them.

But if the therapist has the capacity to relent, it will be so much easier, ultimately, for the patient herself to relent, to admit, to acknowledge, to take ownership of, to back off, to surrender, and to let go. In essence, the patient's defensive relentlessness will become less toxic by virtue of the fact that the therapist has been able to lend aspects of her own healthier functioning and greater capacity to a psychological processing and detoxification of *relentlessness* that the patient has provoked within her—relentlessness that is initially *projection* and eventually *reality*.

Projective Identification and Containment

A successful projective identification requires of the therapist that she have the capacity to tolerate what the patient finds intolerable.

Projective identification has two phases (Stark, 1994a, 1994b, 1999, 2015a, 2015b). The induction phase commences once the patient projects onto the therapist some aspect of the patient's experience that has been too toxic for the patient to process and integrate and then exerts pressure on the therapist to accept that projection, thereby inducting the therapist into the patient's enactment. The resolution phase is ushered in once the therapist steps back from her participation in what has become a mutual enactment and brings to bear her own, more evolved capacity to process and integrate on behalf of the patient, such that what is then re-introjected by the patient can be more easily assimilated into healthy psychic structure. And, if all goes well, this relational dynamic will happen repeatedly, such that there will be gradual detoxification of the patient's internal toxicity—in this current situation, incremental detoxification and containment of Sara's relentlessness.

In my work with Sara, I believe that it was my ability to relent, in the form of my tears, that was re-introjected by Sara, rendering her relentlessness less toxic and thereby enabling her to relent, in the form of her own tears.

If a therapist never allows herself to be drawn in to participating with the patient in her enactments, we speak of a failure of engagement. If, however, a therapist can allow herself to be drawn in to the patient's internal dramas but then gets lost, we speak of a failure of containment —and the potential is there for the patient to be retraumatized.

Although initially the therapist might indeed fail the patient in much the same way that her parent had failed her, ultimately the therapist will challenge the patient's projections by

lending aspects of her otherness, or, as Winnicott (1965) would have described, her *externality* to the interaction—such that the patient will have the experience of something that is *other-than-me* and can take that in. What the patient introjects will be an amalgam, part contributed by the therapist (the adaptive capacity to relent) and part contributed by the patient (the defensive need to be unrelenting).

Because the therapist is not, in fact, as bad as the parent had been, there can be this better outcome—first a repetition of the original trauma but with a much healthier resolution this time, resulting in detoxification of the patient's internal world and integration on a higher level. In essence, in Model 3, by way of negotiating at the intimate edge of sadomasochistic engagement and by virtue of the therapist's capacity both to own her relentlessness and then to relent, the patient's defense of relentlessness will be rendered less toxic.

PROVISION OF CORRECTIVE EXPERIENCE

Model 2—Rendering the Defense Less Necessary

For a patient denied the early-on experience of having her every need recognized and responded to by a parent able, at least for a while, to let herself be shaped by her young child's evolving relational needs, for such a patient, it is crucial that the patient now, within the context of the therapy relationship, be able to encounter a new good object that she can possess and control.

And so, at first, the therapist (a stand-in for the parent) must indeed allow herself to be found as an empathically responsive, mutable object. But when this positive—idealizing—transference is eventually disrupted by the therapist's inevitable empathic failures, the therapist must be able to help the patient deal with the pain of the grief she is experiencing both now in relation to the therapist and early-on in relation to the parent (this latter involving grief that, at the time, was simply too painful to be tolerated).

Bearing the Pain of One's Grief

Within the context of safety provided by the relationship with her therapist, the patient must be able to experience, in the here-and-now, grief against which she has spent a lifetime defending herself—confronting, at last, her anguish and her outrage about the limitations, the separateness, and the immutability of her objects. As the patient confronts—and grieves—the pain of her disappointment in her objects (both past and present) and the fact of their

unrelenting intractability, the patient's erstwhile defense of relentlessness will become less necessary, the pain of her grief now more manageable.

As part of the working through that a patient must do in order to be released from the stranglehold of her tenacious attachments and relentless pursuits, she must come not only to know with her head (cognitively) that her dysfunctional defenses have become too costly for her to maintain but also to feel with her heart (affectively) that these self-protective mechanisms are no longer serving her.

All change, even if for the better, involves loss and, as such, must be grieved. As part of that mourning process, the patient will need to deal with disappointment, frustration, and heartbreak experienced in relation to not only her transference object and her contemporary objects but also her infantile objects. And, more generally, she will need to deal with the destabilizing stress and discombobulating upset of having her time-honored—albeit maladaptive—ways of being and doing challenged and her all-too-familiar-and-oh-so-comfortable-but-fundamentally-flawed defensive stance in the world called into question.

Genuine grieving requires of us that we be able, at least for periods of time, to be fully present with the anguish of our grief and the fury we will experience when we are confronted with inescapable and shocking realities about ourselves, our relationships, and our world. We must not absent ourselves from our grief; we must enter into and embrace it, without running away. We cannot effective grieve when we are dissociated, missing in action, or fleeing the scene. We need to be present, engaged, in the moment, mindful of all that is going on inside of us, grounded, focused, and in the here-and-now. If, instead, we are in denial, unwilling to confront, closed, shut down, numb, retreating, refusing to feel, protesting, or refusing to accept, then no real grieving can be done.

A Disillusionment Statement

I have developed another therapeutic intervention, a *disillusionment statement*—an intervention specifically designed to facilitate the patient's grieving of her heartbreak in the aftermath of disappointment (Stark 1994a, 1994b).

The format of a disillusionment statement is as follows:

You are coming to know the disillusioning reality that… / and it breaks your heart…

To Sara, I would say things like—

"You know that there are times when, despite my best efforts, I just don't get it quite right, and it makes you angry and sad."

"You are coming to the painful realization that your mother will never love you in the tender and gentle way that you would so have wanted to be loved, and it fills you with deep sadness."

"You are beginning to recognize that your mother will never be willing to apologize to you for all the pain and suffering that she has caused you over the course of the years, and it is devastating."

In essence, in Model 2, by juxtaposing both disillusioning realities that the patient is slowly coming to recognize with the pain of her grief about those disillusionments, a series of disillusionment statements will give the patient space to confront, and grieve, her devastating heartbreak about painful realities against which she has long been defending, thereby rendering less necessary her defensive—and unrelenting—refusal to confront intolerably painful realities.

Making One's Peace with Reality and Moving On

Genuine grieving—usually accomplished only incrementally and over time—is an ongoing torturous and tortuous process of alternately falling into the depths of devastation and heartbreak and then raging against the world and railing against our fate. But, ultimately and as noted throughout, it involves forgiving, relenting, letting go, separating, and moving on. It is what it is; it was what it was; and, at the end of the day, as the Serenity Prayer reminds us, we must accept the things that we cannot change, must have the courage to change the things that we can, and must have the wisdom to know the difference (Sifton 2005).

The patient must come to accept the reality that she is ultimately powerless to do anything to make her objects, both past and present, different. She can, and should, do things to change herself, but she cannot change her objects and she will have to come to terms with that sobering truth. Such is the work of grieving and mastering the experience of loss, disappointment, heartbreak, and defeat; such is the work of making one's peace with reality and moving on.

Transformation of Defense into Adaptation

As noted earlier, growing up (the task of the child) and getting better (the task of the patient) have to do with transforming id into ego (Freud 1923), energy into structure, need into capacity, defense into adaptation—more specifically, transforming the infantile need to possess and control the object and, when thwarted, to attempt destruction of it into the healthy capacity to relent, accept, forgive, internalize, separate, let go, and move on. This evolutionary process is facilitated by grieving, as peace is made with the reality that one's objects in the here-and-now will never be able to compensate for early-on parental deficiencies.

In essence, both the developmental process and the therapeutic process are stories about transforming relentlessness and the refusal to grieve (both of which are defenses) into serene acceptance (an adaptation)—as the unhealthy need to pursue the unattainable gradually evolves,

through a series of disruptions and repairs, into the healthy capacity to relent, accept, forgive, let go, and move on. Sadder perhaps, but wiser too.

As painful realities are grieved, infantile, unrealistic hope will be replaced by mature, more reality-based hope. Along these lines, Searles (1979) has suggested that realistic hope arises in the context of surviving disappointment.

Sara Relents and Forgives

In my work with Sara, there did indeed come a time when Sara was able, at last, to confront the pain of her grief about the objects in her world and was then able to relent, accept, forgive, and let go of her relentless pursuits. She was finally able to sit with the pain of her grief about both me and, in time, her mother; and she finally forgave us both. In the words of the theologian Smedes (1984), "To forgive is to set a prisoner free and <to> discover that the prisoner was you."

Our work is now done. And Sara no longer needs me in the way that she once did, but she stays in touch, much to my great delight. Sara's work with me was the hardest thing she ever did; and, quite frankly, my work with Sara was one of the hardest things I have ever done.

CONCLUSION

The patient's relentless hope and relentless outrage must become transformed into the healthy, adult capacity to accept the sobering reality that one cannot make one's objects change but that one can and must take ownership of, and responsibility for, all that one can change within oneself. In fact, it could be said that maturity and mental health involve transforming the infantile need to force one's objects to change into the healthy capacity to accept them as they are.

Indeed, as the patient's relentlessness is rendered less adaptive, less necessary, and less toxic, it becomes transformed into the capacity to relent, to accept, to forgive, and to take control of, and responsibility for, one's own life—no longer needing one's objects to be something they are not now and will never be...

ADDENDUM

What follows is an extended version of the clinical vignette briefly summarized above. This original version of Sara's story, written a number of years ago, was titled "The Unforgivable Mistake." I present it, below, as it was written then.

I have been seeing Sara, an exceptionally gifted 55-year-old therapist, four times a week for the past five years.

Five years ago, at the very beginning of our work together, I said something to Sara that made her feel I did not want to work with her. (I apologize for not being able to share with you the specifics of what I actually said, but Sara asked me, please, not to. She did, however, give me permission to share the rest.)

Sara considers what I said to her in our third session those five years ago to have been a mistake for which she will never be able to forgive me, although she desperately wishes that she could.

At the time, I was horrified that Sara would have so misunderstood what I was saying; but given what I have since come to know about her, I can now appreciate why what I said was indeed deeply hurtful to her.

Over the course of our years together, Sara has spent much time trying to decide whether or not she feels safe enough to continue our work. But because of the unforgivable mistake that I made those five years ago, she fears she may never be able to trust me.

Although periodically I have attempted to clarify (rather defensively I am sure) what I had thought I was trying to say in our third session those five years ago, understandably Sara has not been all that interested in listening and has held fast to her experience of me as untrustworthy and of the therapy as a place that is not safe—certainly not safe enough to bring her pain, her tears, her anger, her loneliness.

Over time, what Sara and I have come to understand about our dynamic is that we have unwittingly recreated (between us) the mutually torturing relationship that she had with her toxic mother. At times, Sara is her bad mother and I am Sara who, as a little girl, was tormented by her double-binding mother. At other times, I am her bad mother and Sara is tormented by me as she was once tormented by her mother.

In my work with Sara, it has been extremely important to her that I be able to confirm her experience of things, not just that I validate her perceptions as *plausible constructions* of reality (Hoffman 1983) but that I actually confirm them. In other words, Sara needs me to agree that her reality is *the truth*. Otherwise, she begins to feel crazy.

Almost without fail I have been able to confirm Sara's perceptions, most of which have seemed to me to be uncannily on target.

Unfortunately, some of her uncannily accurate perceptions have been about me. Although it is more difficult when the focus is on me and my vulnerabilities, ultimately (with the one exception noted above) I have been able—and willing—to confirm these perceptions as well.

As an example of how Sara will zero in on me: When recently she came to a session and asked to schedule a number of extra sessions, I was obviously very pleased (I actually said something to the effect of, "Yes! Yes! Yes!"). Indeed it meant a great deal to me that she would want the extra time, particularly in light of her experience of me as having failed her so

unforgivably early-on in our relationship.

So we spent some time scheduling the extra sessions and then I said, gently: "You know I am so pleased to be scheduling additional appointments, but it occurs to me that I should be asking you how you feel about having these extra sessions."

Sara did not answer for a long time. After what seemed like an eternity to me, she said finally, sadly, that she was now not sure the extra sessions were such a good idea after all; she said that she was suddenly feeling that maybe I did not really want her to be coming for the additional appointments.

Although I was initially stunned by her response, in time she helped me to understand something that I had not previously understood: By asking Sara to share with me how she felt about having the extra sessions, I was, in a way, humiliating her. Obviously she would not have asked for this extra time if a part of her had not wanted the additional contact with me. So my asking of her that she admit to wanting more time with me was, in a way, tantamount to my forcing her to acknowledge having desire in relation to me. Indeed, had I, in advance, thought more about my somewhat formulaic question, then I would probably have known not to ask it.

What I now understood was that by asking her to tell me how she was feeling about getting the extra time, I really was more *going by the book* than *coming from my heart*. I had been taught that it is always important to explore whatever underlying expectations, hopes, or fears the patient might have whenever she asks for something from her therapist. So I really was more going by the book than by what I did know (deep inside of me), namely, that despite Sara's deep reservations about me, a part of her was beginning to trust me a little more and was wanting me to know this without her having to say it outright.

Indeed, I came to see that Sara's experience of me as having humiliated her was not just a

story about her but also a story about me. I was able to understand that I really was shaming her by asking of her that she acknowledge wanting to have the extra time with me.

Sara has been a wonderful teacher—she has devoted considerable time and energy to teaching me to be a better therapist to her and, in all honesty, a better therapist period. I am so much wiser for my time with her. I am increasingly coming to see how often I will unconsciously fall back on going by the book instead of coming from my heart—not always in the big ways, but in the little ways (some of the rituals, some of the routines that I will do without really thinking them through).

This we have accomplished.

But there has been between us the ongoing issue that we have not yet been able to resolve, namely, what to do with respect to the unforgivable mistake I made those numbers of years ago—about which I feel absolutely terrible and for which I have apologized many times over from the bottom of my soul.

Periodically Sara will turn to me and ask, point-blank, that I confirm her perception of me as having failed her unforgivably in that third session those five years ago. And, over the years, she has made it very clear that were I to confirm that perception, she would have no choice but to terminate her treatment with me. On the other hand, when I do not confirm that perception, then she feels she has no choice but to continue to feel unsafe.

When Sara and I get into this place, as we have so many times over the course of our years together, my mind almost snaps from the pressure of how crazy-making the whole thing is. By asking of me that I confirm her perception of me as untrustworthy and of my early-on mistake as unforgivable, Sara puts me in an untenable position. But by holding on to my wish that Sara would someday both trust me and forgive me, I too put Sara in an untenable position. Sara asks

of me something that I cannot possibly do; but then I ask of her something that she cannot possibly do.

It is indeed agony for us both, yes—but it is also telling, telling us a great deal about the toxic relationship that she had with her mother. I believe we are doing the work that needs to be done, namely, attempting to negotiate our way through and out of this convoluted, mutually torturing, hopelessly enmeshed relationship that is, in fact, a recreation of the double-binding, no-win relationship she had with her mother. It is a mutual enactment—in which both of us are participating.

But by way of the drama that is being re-enacted between us, Sara is enabling me to experience, firsthand, what the experience must have been like for her in relation to her mother. We will need someday to find our way out of this Catch-22 situation—but, for now, we must both sit with the uncertainty of not knowing what will ultimately unfold.

The other day, however, something different did happen. Sara was once again begging me to admit that what I had said to her those numbers of years earlier was unforgivable. As I listened, I found myself feeling so sad, so trapped, so anguished, and so tormented that I suddenly burst into tears. I rested my head in my hands and just sobbed. Sara sat there very still, barely breathing, watching, waiting. Eventually I stopped, and we continued our talking. This time I knew not to ask her the pat question: "How was it for you, my crying?"

But later in the session, I think she showed me what it must have been like for her. She herself began to cry—she put her head in her hands and wept. Now I sat there very still, barely breathing, watching, waiting. What made it particularly poignant for me was my knowing that she (as an adult) had never before cried in front of anyone.

Our work continues.

REFERENCES

Ehrenberg, D.B. (1992). *The Intimate Edge: Extending the Reach of Psychoanalytic Interaction*. New York, NY: W.W. Norton.

Fairbairn, W.R.D. (1954). *An Object-Relations Theory of the Personality*. New York, NY: Basic Books.

Freud, S. (1923). The ego and the id. *Standard Edition* 19:1-66.

Hoffman, I.Z. (1983). The Patient as Interpreter of the Analyst's Experience. *Contemporary Psychoanalysis* 19:389-422.

Mitchell, S. (1988). *Relational Concepts in Psychoanalysis*. Cambridge, MA: Harvard University Press.

Rako, S., Mazer, H., Semrad, E. (1983). *The Heart of a Therapist*. Northvale, NJ: Jason Aronson.

Russell, P. (1980). The theory of the crunch (unpublished manuscript).

Searles, H. (1979). The development of mature hope in the patient-therapist relationship. In *Countertransference and Related Subjects: Selected Papers*, pp. 479-502. New York, NY: International Universities Press.

Sifton, E. (2005). *The Serenity Prayer: Faith and Politics in Times of Peace and War*. New York, NY: W.W. Norton.

Smedes, G. (1984). *Forgive and Forget: Healing the Hurts We Don't Deserve*. New York, NY: HarperCollins.

Stark, M. (1994a). *Working with Resistance*. Northvale, NJ: Jason Aronson.

----- (1994b). *A Primer on Working with Resistance*. Northvale, NJ: Jason Aronson.

----- (1999). *Modes of Therapeutic Action: Enhancement of Knowledge, Provision of Experience, and Engagement in Relationship*. Northvale, NJ: Jason Aronson.

----- (2015a). *The Transformative Power of Optimal Stress: From Cursing the Darkness to Lighting a Candle*. IPI eBook available through www.FreePsychotherapyBooks.org.

----- (2015b). *Psychotherapeutic Moments: Putting the Words to Music*. IPI eBook available through www.FreePsychotherapyBooks.org.

Winnicott, D.W. (1965). *The Maturational Processes and the Facilitating Environment*. New York, NY: International Universities Press.

Zevon, C. (2008). *I'll Sleep When I'm Dead: The Dirty Life and Times of Warren Zevon*. New York, NY: HarperCollins.