TRANSFORMATION OF RELENTLESS HOPE:
A Relational Approach to Sadomasochism

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INTRODUCTION

I want to speak to something to which I refer as “relentless hope,” the hope 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 rage in those moments of dawning recognition that, despite her best efforts and her 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 rage) 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) – 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 entitled "If You Won't Leave Me, I'll Find Someone 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 may 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.

It is to Winnicott 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, be able to gratify if her child is ever to move successfully beyond this early stage in its development. Says 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 over her objects. The thwarted need will become reinforced over time, ever more charged, ultimately manifesting as a relentless drive to possess and control the objects in her world and, when confronted with the limits to her imagined omnipotence by their refusal to relent, a drive to retaliate by attempting to destroy them.

And it is to Fairbairn 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 – which is 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 – to which she is both libidinally and aggressively attached – a seductive 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 will later devastate by rescinding that enticement.

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 (because they are separate and cannot be possessed), though they are compellingly appealing by virtue of their enticing seductiveness.

As I hope later to demonstrate, 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 makes possible transformation of the patient's relentless hope and, when thwarted, her relentless rage into the healthy capacity to accept the reality that her objects will not always 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 and its limitations; and her relentless rage (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, emotionally available parent whom she never had reliably and consistently early-on.

Parenthetically, I do not limit sadomasochism to the sexual arena; rather, I conceive of it as a relational dynamic that gets played out, to a greater or lesser extent, in most of our intimate relationships.

More specifically, masochism is a story about the patient's hope, her relentless hope, mobilized in response 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 (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...

Sadism is the response to disappointment of the relentlessly hopeful patient. The healthy response to disillusionment is to confront it and grieve it, feeling all that needs to be felt in order

ultimately to come to terms with the reality of it. But, as we have seen, the patient who is relentless cannot tolerate the pain of her disappointment. Instead, she feels hopeless, helpless, and despairing.

And with the patient's dawning recognition that she is not going to get her way after all and powered by her belief that she has been duped, conned, betrayed, she may respond with the unleashing of a torrent of abuse 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 it).

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

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

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

If the therapist 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).

Better, then, to 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 by not fulfilling an implicit promise the therapist had earlier made. 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 have played by first stoking the flames of the patient's desire and then devastating through her failure, ultimately, to deliver.

To this point, our focus has been on the way in which sadomasochism manifests itself relationally and we used Fairbairn to help us understand the underlying endopsychic situation -- namely, that the patient has both a libidinal and an aggressive attachment to the bad object (thus the ambivalence of her attachment and the relentlessness of her pursuit). I believe that these same patients have both a libidinal and an 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 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 – an eating disorder with eating binges (gratification of libido) alternating with episodes of fasting (gratification of aggression). The vicious cycle would then go as follows: The patient, feeling deprived, becomes resentful and then feels entitled to gratify herself by indulging 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 rage) or internally (in the form of alternating cycles of self-indulgence and self-destructiveness) – though here our focus will be on the enactment of sadomasochism relationally.

THERAPEUTIC ACTION

So I would like now to address 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 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.

Elsewhere I have described three modes of therapeutic action:

Model 1 – enhancement of knowledge "within" (the interpretive perspective of classical psychoanalytic theory) – something else;

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

Model 3 – engagement in relationship "with" (the relational perspective of contemporary psychoanalytic theory and those object relations theories – like Fairbairn's – that emphasize the "presence of bad") – something more.

I will now be suggesting that the most effective approach for dealing with the patient's relentlessness (both her masochism and her sadism) will be one that draws upon all three modes of therapeutic action.

But first I want to reiterate the importance of understanding the patient's relentlessness as 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 rage speak, then, to the operation of the patient's defenses; both the masochistic defense of relentless hope and the sadistic defense of relentless rage are fundamentally self-protective responses to intolerably painful truths about

the object's limitations, its separateness, and its refusal to relent.

THE PROCESS OF TRANSFORMING THE PATIENT'S RELENTLESSNESS

As with all defenses, the patient's relentlessness, before it can be relinquished, 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).

In order to demonstrate the translation of theory into practice, I will be using a clinical vignette, one with which some of you may already be familiar – the case of Sara, a woman with whom I worked for many years, seeing her as often as four to five times a week, but with whom, at the very beginning of our work, I had made a mistake that she considered unforgivable, making her feel that she would never be able to trust me.

Over the course of many years, Sara's need became to force me to admit not only that I had made a mistake (which I was readily 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, 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 always had with her toxic mother – at times Sara was in the role of her bad mother and I was in the role of Sara, the little girl tormented by her double-binding mother; at other times it was I who was in the role of her bad mother and Sara who was tormented by me as she had once been tormented by her mother.

This 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 – not until one day, in response 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 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, though 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.

Although in any treatment all three modes of therapeutic action (enhancement of knowledge, provision of experience, and engagement in relationship) operate simultaneously, for the purposes of my presentation this morning, I will 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 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 ultimately relent. Accountability and the capacity to relent are where the therapeutic action lies.

Model 1, in which the defense of relentlessness is rendered 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), 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, where appropriate articulating the very real shock and horror she experiences in the face of the patient's self-indulgent and self-destructive relentlessness.

The therapist, of course, must avoid becoming moralistic or judgmental. It's 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 may well respond with an intensification of her defensive efforts and, therefore, 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.

In the interest of time, I would like to focus now on two therapeutic interventions that I have developed to enhance the patient's knowledge of how she enacts her sadomasochism in relationship.

The format of a masochism statement is as follows:

Although you know thus-and-such / it hurts too much to sit with the pain of that / and so you keep hoping... (and feel entitled...)

To Sara, I said 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 the thought of that seems too overwhelming. And so a part of you keeps hoping that maybe someday things will simply get better without your having to do anything."

"On some level, you know that your husband will never be the kind of sensitive and finely tuned that you would have wanted him to be. But it makes you too sad to think about all that right now. So periodically you find yourself pressuring him to try just a little harder."

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

The format of a sadism statement is as follows:

When you feel hurt, misunderstood, 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 and your anger. I think there's also a part of you that feels such outrage at my insensitivity that you then feel justified in trying to hurt me back."

"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, if you're not careful, you

can slip into another one of your self-castigating depressions."

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

"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 just stop caring about anything."

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 rage) 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 grief about them, their limitations, and their separateness.

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, been adaptive and 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 her defense, how costly, maladaptive, and ego-dystonic it has been – in other words, the "pain." Sara was indeed able ultimately to take ownership of her relentlessness, to understand the gain, and finally to recognize the pain.

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

And once the pain becomes greater than the gain, the strain so created will 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 so created will then provide the therapeutic leverage for the patient to relent.

So in Model 1, when the patient's relentlessness is in the limelight, enhancement of knowledge (with an edge) rendering the defense less adaptive.

Model 3. Now for Model 3, in which the defense of relentlessness is rendered 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 has to do with the comfort of the familiar but the healthy piece of which has 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, inevitably the therapist will find herself responding to 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 sadomasochistic dance that ensues between patient and therapist will be tormenting for both and may last for weeks, months, years – until somebody does something. It is the therapist's responsibility to do that something. If there is to be resolution of their stalemated, gridlocked "crunch" situation, then what the therapist must be able to do is to relent, to give in, 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 the judge who, when asked to define pornography, said simply "You know it when you see it."

The therapist's capacity to relent may take the form of being able to let go of her need to be right, her need to win, her need to have her own way; or, being able to relinquish her need to make the patient better, make the patient gain insight, make the patient experience more affect, make the patient deliver more of herself into the relationship. Or the therapist's relenting may 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, to give it up – in essence, the patient's defense of relentlessness will become less toxic once the therapist has lent aspects of her own healthier functioning and greater capacity to a psychological processing and detoxification of the relentlessness the patient has projected onto her, such that what the patient then introjects will be an amalgam, part the patient's original projection and part the healthy capacity to relent introduced by the therapist.

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

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.

Model 2. Finally, and briefly, Model 2, provision of experience, in which the defense of relentlessness is rendered 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 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 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 experienced both now in relation to the therapist and early-on in relation to the parent – this latter, grief that at the time was simply too painful to be tolerated.

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 separateness, the immutability, and the relentlessness of her objects, particularly the intractable parent. As the patient confronts – and grieves – the pain of her disappointment in her objects (both past and present) and the fact of their unrelenting separateness, the patient's erstwhile defense of relentlessness will become less necessary, the pain of her grief now more manageable.

Growing up (the task of the child) and getting better (the task of the patient) have to do with transforming id into ego ("where id was, there shall ego be"), energy into structure, need into capacity – 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 – a process facilitated by grieving, as peace is made with the reality that one's objects in the here-and-now will not always be able to compensate for early-on parental deficiencies.

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. 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.

In conclusion: The patient's relentless hope and relentless rage 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. The Serenity Prayer speaks directly to this issue: "God grant me the serenity to accept the things I cannot change; courage to change the things I can; and the wisdom to know the difference."

In fact, it could be said that maturity and mental health involve transforming the infantile need to make one's objects over into something they are not 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...