NAVIGATING THE "RELENTLESS HOPE" OF PATIENTS WITH BORDERLINE FEATURES:

AN INTEGRATIVE APPROACH TO DEVELOPING EVOCATIVE MEMORY, MENTALIZATION, AND THE CAPACITY TO GRIEVE

Thursday, August 28, 2025 | 12:00 – 2:00 pm (ET)

Presented by Martha Stark MD | Harvard Medical School

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MANY PATIENTS

– REFUSING TO CONFRONT AND GRIEVE UNBEARABLY PAINFUL TRUTHS
ABOUT THE OBJECTS OF THEIR DESIRE –
(WHETHER INFANTILE, CONTEMPORARY, OR TRANSFERENCE)

SPEND A LIFETIME IN PURSUIT
OF SOMETHING THAT NEVER WAS

– NAMELY, THE LONGED – FOR EXPERIENCE OF "PERFECT" OR "IDEALIZED" CAREGIVING –

MORE SPECIFICALLY

THEIR UNRELENTING SEARCH FOR
"PERFECT EMPATHIC ATTUNEMENT"
– TO BE DEEPLY SEEN, SECURELY HELD, AND NEVER FORSAKEN –
BETRAYS THEIR REFUSAL TO ACCEPT
THE LIMITATIONS, THE SEPARATENESS,
AND THE UNYIELDING IMMUTABILITY OF THEIR OBJECTS
– THE SIMPLE BUT DEVASTATING REALITY THAT THOSE OBJECTS
CANNOT BE FORCED TO BE SOMETHING THEY ARE NOT –

AND SO, THEY REMAIN INESCAPABLY TRAPPED IN A FUTILE QUEST,
CLINGING TO A DREAM THAT CAN NEVER BE REALIZED

I REFER TO THIS UNWAVERING LONGING
FOR "IDEALIZED PERFECTION"
– THIS LIFETIME OF YEARNING FOR THE IMPOSSIBLE –
AS "RELENTLESS HOPE"

AT THE CORE OF "RELENTLESS HOPE"
IS THIS "RELENTLESS PURSUIT OF THE UNATTAINABLE"
– A DESPERATE YEARNING FOR SOMETHING THAT CAN NEVER BE –
– A PERSISTENT WISH FOR THINGS TO BE OTHER THAN AS THEY ARE –

. . . FUELED BY THE "ILLUSION OF PERFECTION"
– OR THE PERFECTIBILITY –
OF SELF AND OTHER

THE RELENTLESSNESS OF THE PURSUIT ARISES
FROM THE "DEVELOPMENTALLY DISRUPTED"
"NARCISSISTIC NEED FOR PERFECTION"
– AGE – APPROPRIATE AT THE TIME
BUT "TRAUMATICALLY THWARTED" EARLY ON BY THE CAREGIVER,
NEVER "WORKED THROUGH, REFRAMED, OR INTEGRATED,"
AND THEREFORE "RELENTLESSLY PRESENT" IN THE HERE – AND – NOW –

UNFORTUNATELY
THIS "INFANTILE NEED FOR NARCISSISTIC GRATIFICATION"
DOES NOT SIMPLY PERSIST "AS IS"

RATHER
IT BECOMES "DEFENSIVELY REINFORCED" OVER TIME
– INTENSIFYING PRECISELY BECAUSE
IT WAS NEVER ADEQUATELY FULFILLED –

THE RELENTLESS HOPE
OF PATIENTS WITH "NARCISSISTIC VULNERABILITY"
– THOSE WHO HAVE NOT YET FULLY RELINQUISHED
THEIR "INFANTILE NEED FOR PERFECTION" –
DIFFERS SUBTLY FROM THAT
OF PATIENTS WITH BORDERLINE PERSONALITY DISORDER (BPD)

FOR THE LATTER
THE HOPE IS FAR MORE LAYERED, ANGUISHED, AND COMPLEX
– ARISING NOT MERELY FROM A "REFUSAL" TO GRIEVE, BUT FROM AN "INABILITY" TO DO SO –

BECAUSE OF THEIR SERIOUSLY COMPROMISED CAPACITIES
FOR BOTH "EVOCATIVE MEMORY" AND "MENTALIZATION,"
THESE PATIENTS FIND IT NEARLY IMPOSSIBLE
TO "HOLD IN MIND" THE MEMORY OF PAST "GOOD"
IN THE FACE OF THE PRESENT "BAD"

UNABLE, THEREFORE, ADAPTIVELY TO INTERNALIZE WHATEVER GOOD THERE ONCE WAS,
THEY CANNOT PRESERVE WITHIN THEMSELVES EVEN A PIECE
OF THE ORIGINAL EXPERIENCE OF EXTERNAL GOODNESS

AND SO, TRAGICALLY CONDEMNED TO REPEAT,
THEY REMAIN TENACIOUSLY CAUGHT
IN THE WEB OF THEIR RELENTLESS PURSUIT

Lois W. Choi-Kain, M.D. M.Ed. D.F.A.P.A. · 1st
Director, Gunderson Personality Disorders Institute at McLean Hos...
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2h ·

Don't miss the most concentrated scientific program for updates on personality disorders this year at the ISSPD Congress in Boston November 9-11, 2025. Our full program will be published soon, but in the meantime, we will start previewing highlights of interest for clinicians, researchers, students, and people living with personality disorders. Register now to be in the company of a vibrant community of people dedicating their efforts to improving the understanding and treatment of personality disorders.

https://lnkd.in/ey6hGHCw

MANY PATIENTS STRUGGLE

– AT LEAST TO SOME DEGREE –

WITH EMOTIONAL DYSREGULATION, INSECURE ATTACHMENT,
PRECARIOUSLY ESTABLISHED SELF – ESTEEM,
DISTORTIONS IN SELF – CONCEPT, TRUST ISSUES,
AND RELATIONAL DYSFUNCTION

BUT, AS I WILL BE SUGGESTING THROUGHOUT,

PATIENTS WITH BORDERLINE DYNAMICS CARRY
AN ADDITIONAL LAYER OF NUANCE AND COMPLEXITY

. . . CHARACTERIZED BY PROFOUND PSYCHIC FRAGILITY,
EMOTIONAL VOLATILITY, ANGUISHED HEARTBREAK,
DEFENSIVE "SPLITTING," DYSREGULATED IMPULSIVITY,
AND A PERVASIVE SENSE OF HAVING BEEN DEEPLY BETRAYED

THESE ARE THE ELEMENTS THAT SET THEM APART

– THAT FUEL A UNIQUELY GRIEF – STRICKEN, TORMENTED, FRAGMENTED,
INTERNALLY CHAOTIC, AND OFTEN CRISIS – RIDDEN EXISTENCE –

THEIR "FRACTURED EXPERIENCE OF BEING"
IS SUCH THAT INTENSE EMOTIONS FEEL LIKE MAELSTROMS

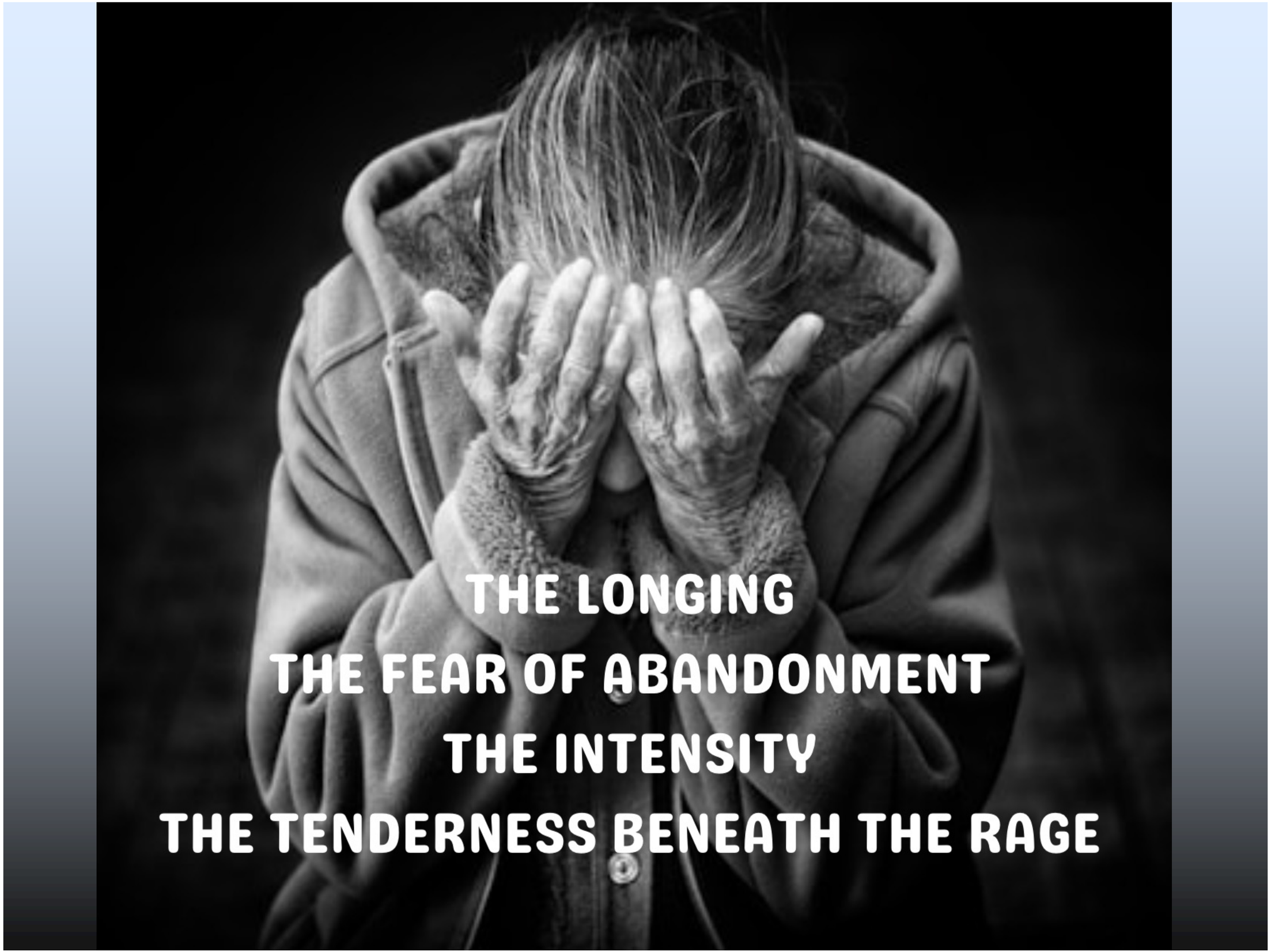
– EACH ONE A TURBULENT, ALL – CONSUMING FORCE,
PULLING THEM EVER DEEPER INTO AN EXISTENTIAL VORTEX
OF CONFUSION, HELPLESSNESS, AND DESPAIR –

THIS IS WHAT MAKES WORKING WITH SUCH PATIENTS
IN TREATMENT ESPECIALLY DEMANDING
– ALTHOUGH, ULTIMATELY, EXTRAORDINARILY REWARDING –

THE PATIENT CAN QUICKLY BECOME A FORMIDABLE OPPONENT
– FIERCELY COMBATIVE WHEN TRIGGERED –
– PARTICULARLY BECAUSE OF THEIR NOTORIOUSLY LIMITED CAPACITY TO "CONTAIN" THEMSELVES
IN THE FACE OF DISILLUSIONMENT, DISAPPOINTMENT, REJECTION, LOSS,
PERCEIVED THREAT, OR EMOTIONAL OVERWHELM –

. . . ULTIMATELY LEADING TO THE WELL – KNOWN
– AND ALMOST INEVITABLE –
"ACTING OUT" OF THEIR CRUSHING PAIN, PROFOUND DESPAIR,
AND ENTITLED OUTRAGE

ALL OF THIS NOTWITHSTANDING
THE TENDER AND SOULFUL VULNERABILITY OF THE PATIENT
– HER EXQUISITE SENSITIVITY, PASSIONATE INTENSITY, DISARMING AUTHENTICITY,
AND GIFT FOR DEEP RELATIONAL PRESENCE WHEN SHE FEELS SAFELY HELD AND TRULY SEEN –
MAKE OF HER
– AT TIMES –
A SHEER PLEASURE AND ABSOLUTE DELIGHT
TO ENGAGE WITH IN TREATMENT


THE LONGING
THE FEAR OF ABANDONMENT
THE INTENSITY
THE TENDERNESS BENEATH THE RAGE

MELANIE KLEIN

THE PARANOID – SCHIZOID POSITION

– PRE – AMBIVALENCE –

THE DEPRESSIVE POSITION

– AMBIVALENCE –

WHAT INSIGHTS DOES THE PSYCHOANALYTIC LITERATURE OFFER INTO THE ETIOLOGY OF BORDERLINE PSYCHOPATHOLOGY?

THE PATIENT WITH BORDERLINE FEATURES
OPERATES FROM WHAT
MELANIE KLEIN (1964) REFERS TO AS
THE "PRE – AMBIVALENT" STAGE OF DEVELOPMENT
– THE STAGE THAT CHARACTERIZES THE "PARANOID – SCHIZOID POSITION,"
IN WHICH OTHERS ARE EXPERIENCED AS "PART – OBJECTS" –
– AS EITHER "NEED – GRATIFYING" (AND "ALL – GOOD")
OR "NEED – FRUSTRATING" (AND "ALL – BAD") –

THIS PRIMITIVE "DEVELOPMENTAL POSITION"
IS MARKED BY "RUTHLESSNESS"
– A "LACK OF CONCERN" FOR OTHERS –

BECAUSE PATIENTS WITH BORDERLINE FEATURES
CAN ONLY PARTIALLY NAVIGATE
THE PRE – AMBIVALENT, RUTHLESS PARANOID – SCHIZOID POSITION,
THEY WILL, WHEN "INTERPERSONALLY STRESSED," OFTEN
REVERT TO AN EARLY STAGE OF "PART – OBJECT USAGE"
– WHERE SELF AND OBJECT REPRESENTATIONS ARE RIGIDLY SPLIT
INTO "ALL – GOOD" AND "ALL – BAD" –

WHEN EMOTIONALLY OVERWHELMED,

PATIENTS WITH BORDERLINE FEATURES

– UNABLE TO MAINTAIN THE MORE INTEGRATED STAGE OF “AMBIVALENCE” –

(THE DEFINING CHARACTERISTIC OF MELANIE KLEIN’S “DEPRESSIVE POSITION”)

WILL USUALLY REGRESS TO

THE EARLIER DEVELOPMENTAL STAGE OF “PRE – AMBIVALENCE”

AS WILL SOON BE EXPLORED IN GREATER DETAIL,

THE OVERARCHING GOAL OF TREATMENT FOR SUCH PATIENTS

WILL THEREFORE BE TO SUPPORT

A MORE SUSTAINED AND COHESIVE PROGRESSION

TOWARD THE DEVELOPMENTAL STAGE OF “AMBIVALENCE”

– ALREADY PARTIALLY ATTAINED, YET PRECARIOUSLY HELD –

IN OTHER WORDS, THE AIM IS TO FOSTER ADVANCEMENT

FROM THE “PARANOID – SCHIZOID POSITION”

– MARKED BY “DEFENSIVE SPLITTING” OF “GOOD” AND “BAD,”

A “FRAGMENTED SELF,” AND “PART – OBJECT USAGE” –

(WHERE OTHERS ARE EXPERIENCED AS EITHER

ENTIRELY NEED – GRATIFYING OR WHOLLY NEED – FRUSTRATING)

TO THE “DEPRESSIVE POSITION”

– MARKED BY “ADAPTIVE INTEGRATION” OF “GOOD” AND “BAD,”

A “COHESIVE SELF,” AND “WHOLE – OBJECT RELATING” –

(WHERE ONE CAN HOLD IN MIND, SIMULTANEOUSLY,

THE “BELOVED” AND “REPUDIATED” ASPECTS OF “DISILLUSIONING OBJECTS”

AS WELL AS THE “NUTURING” AND “DESTRUCTIVE” ASPECTS OF THE ”SELF”)

MARGARET MAHLER

THE SEPARATION – INDIVIDUATION PROCESS

– ESPECIALLY THE RAPPROCHEMENT SUBPHASE –

BORDERLINE DIFFICULTIES HAVE OFTEN BEEN LINKED
TO CHALLENGES IN NEGOTIATING MARGARET MAHLER'S (1975)
"SEPARATION – INDIVIDUATION PROCESS" (5 TO 36 MONTHS)

THIS IS A "SENSITIVE" DEVELOPMENTAL PERIOD
DURING WHICH THE YOUNG CHILD
BEGINS TO DIFFERENTIATE HERSELF FROM THE PRIMARY CAREGIVER
– USUALLY THE MOTHER –
AND GRADUALLY DEVELOPS A SENSE OF INDIVIDUALITY
– A SEPARATE IDENTITY –
AS SHE MOVES TOWARD GREATER INDEPENDENCE AND AUTONOMY

WITHIN THIS PROCESS,
THE RAPPROCHEMENT SUBPHASE (15 TO 24 MONTHS)
IS ESPECIALLY "CRITICAL"
BECAUSE IT IS DURING THIS TIME THAT THE YOUNG CHILD
– TRAPPED IN THE PUSH – PULL BETWEEN AUTONOMY AND DEPENDENCE –
– STRUGGLING TO MOVE AWAY FROM THE MOTHER
YET STILL NEEDING HER FOR "EMOTIONAL REFUELING" –
IS HIGHLY VULNERABLE TO ABANDONMENT TRAUMA
AND TO THE IMPACT OF INCONSISTENT OR UNATTUNED PARENTING

IT IS THOUGHT THAT THE CAREGIVER OF A CHILD
WHO LATER DEVELOPS BORDERLINE ISSUES
– OFTEN HERSELF ORGANIZED AROUND A BORDERLINE STRUCTURE –
CANNOT TOLERATE THE CHILD'S
AGE – APPROPRIATE MOVEMENT AWAY FROM HER

MORE SPECIFICALLY

THE CHILD'S EMERGING DRIVE TOWARD SEPARATION AND AUTONOMY IS EXPERIENCED BY THE NARCISSISTICALLY VULNERABLE CAREGIVER NOT AS A NATURAL DEVELOPMENTAL PROGRESSION, BUT AS A PROFOUND PERSONAL BETRAYAL

– A PSYCHIC WOUND INTERNALLY REGISTERED AS EMOTIONAL ABANDONMENT –

AS THE CHILD BEGINS TO SEPARATE AND INDIVIDUATE,

SUCH A CAREGIVER WILL THEREFORE ENACT A PATTERN OF RADICAL INCONSISTENCY

– AT TIMES SMOTHERINGLY PRESENT AND PSYCHICALLY ENGULFING –
(THE SO – CALLED "SMOTHER MOTHER")
– AND AT OTHER TIMES INACCESSIBLE, WITHDRAWN, OR EMOTIONALLY ABSENT –

SHE WILL BE ALTERNATELY OVERPROTECTIVE, INTRUSIVE, AND DEMANDING AND THEN HOSTILE, REJECTING, OR EMOTIONALLY DISTANT

THIS IS A LIVING DRAMATIZATION OF HER OWN UNRESOLVED INTERNAL SPLIT, WHICH SHE IS EXTERNALIZING AND ENACTING IN THE RELATIONAL FIELD

– LEAVING THE CHILD IN A CONSTANTLY SHIFTING RELATIONAL EXPERIENCE THAT OSCILLATES BETWEEN ENGULFING AND ABANDONING –

BECAUSE SUCH PATIENTS HAVE BEEN SUBJECTED
TO THE CONFUSING AND DISORIENTING
“WHIPLASH” EXPERIENCE
OF SWINGING ABRUPTLY AND UNCONTROLLABLY
– BACK AND FORTH –
BETWEEN
A TRAUMATICALLY DISILLUSIONING
– AND HEART – WRENCHINGLY UNRELIABLE –
PARENT
AND A MYTHICALLY IDEALIZED
– AND HEARTWARMINGLY, THOUGH PRECARIOUSLY, AVAILABLE –
ONE . . .

OVER TIME
THE CHILD HAS NO CHOICE BUT TO ADOPT A WORLDVIEW
DEFINED BY “BLACK AND WHITE”
– WITH LITTLE ROOM FOR NUANCE OR SHADES OF GRAY –

THE CAREGIVER’S “SEDUCTIVENESS”
– FAIRBAIRN’S “SEDUCTIVE MOTHER,” WHO ALTERNATES
BETWEEN EXCITING AND REJECTING HER CHILD –
IS A SOURCE OF PROFOUND DISTRESS
FOR THE VULNERABLE CHILD
– FIRST ENTICING AND COMPELLING,
THEN CRUSHING, DEVASTATING, AND ABANDONING –

ON SOME LEVEL

IT WOULD PROBABLY HAVE BEEN
LESS TORMENTING FOR THE CHILD
HAD THE CAREGIVER BEEN SIMPLY “ALL BAD,”
RATHER THAN FLUCTUATNIG UNPREDICTABLY BETWEEN
THE OCCASIONAL MOMENTS OF BEING “VERY GOOD”
AND THE FAR MORE ROUTINE DEFAULT OF BEING “VERY BAD”

AT LEAST THEN THE CHILD WOULD HAVE HAD
A CLEARER SENSE OF WHERE SHE STOOD

– WITHOUT BEING HELD CAPTIVE BY THE UNCERTAINTY AND THE DESTABILIZING AMBIGUITY
OF NEVER KNOWING FOR SURE WHICH CAREGIVER WOULD APPEAR –

IN ANY EVENT
IN THE FACE OF THE CAREGIVER’S ERRATIC INCONSTANCY
AND HER – OFTEN UNWITTING – SEDUCTIVENESS,
THE IMPRESSIONABLE, HELPLESSLY ENMESHED YOUNG CHILD
IS SUBJECTED
TO THE AGONIZING EXPERIENCE OF ENCOUNTERING
– MORE OFTEN THAN NOT –
A REJECTING AND PAINFULLY FRUSTRATING OBJECT
AND THEN
– ON RARE OCCASIONS –
AN EXCITING AND TANTALIZINGLY GRATIFYING ONE

THIS EXPERIENCE OFFERS THE CHILD
THE FLEETING GIFT OF BEING ABLE
– AT LEAST FOR BRIEF PERIODS –
TO BASK IN THE WARM GLOW OF SOMETHING DEEPLY CHERISHED
– ONLY THEN TO HAVE IT JARRINGLY, INEXPLICABLY, AND INVARIABLY
WRENCHED AWAY AGAIN AND AGAIN –

. . . LEAVING THE CHILD FEELING BETRAYED, STUNNED,
ACHINGLY ALONE, DESOLATE, AND AGONIZINGLY BEREFT,
FOREVER LONGING TO RETURN
– IN MICHAEL BALINT'S POIGNANT WORDS –
TO THE "HARMONIOUS INTERPENETRATING MIX – UP"
– THAT HAD ONCE DEFINED, AT LEAST IN FANTASY, HER ENGAGEMENT WITH
AN EMOTIONALLY AVAILABLE, LOVING, AND YET PARADOXICALLY UNPREDICTABLE CAREGIVER –

AS A RESULT OF THESE OVERWHELMINGLY CONFUSING EXPERIENCES
ONCE THE PATIENT VENTURES OUT INTO THE WORLD,
SHE CARRIES, DEEP WITHIN HER, A DESPERATE LONGING
TO RECLAIM THAT WHICH HAD ONCE BELONGED TO HER
– EVEN IF ONLY BRIEFLY –
BUT THAT WHICH CAN NO LONGER BE FOUND
– AN IDEALIZED PAST THAT NO LONGER EXISTS IN ITS ORIGINAL FORM,
OR PERHAPS NEVER TRULY EXISTED AT ALL –

IN ESSENCE
IT IS AN IDEALIZED PAST THAT IS IRRETRIEVABLE
– A PARADISE LOST, NEVER TO BE RECOVERED –

THEREAFTER

THE PATIENT WITH BORDERLINE FEATURES
WILL SPEND A LIFETIME
FRANTICALLY ATTEMPTING TO RECAPTURE
THOSE PRECIOUS, EPHEMERAL MOMENTS
OF BLISSFUL, DEEPLY INTERCONNECTED UNION

– ONCE EXPERIENCED WITH HER CAREGIVER –

THESE ARE THE MAGICAL

– BUT RARE –

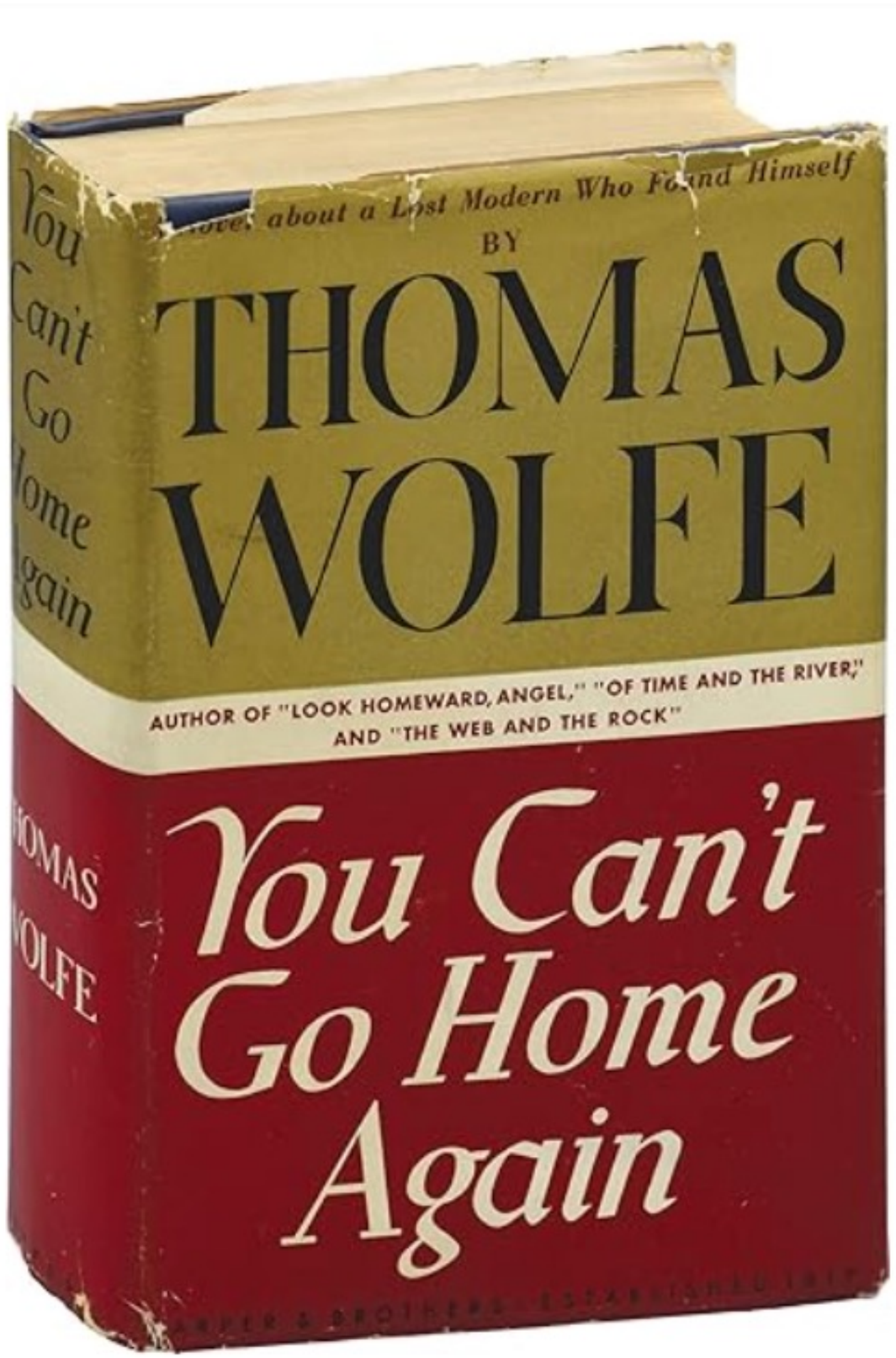
MOMENTS WHEN

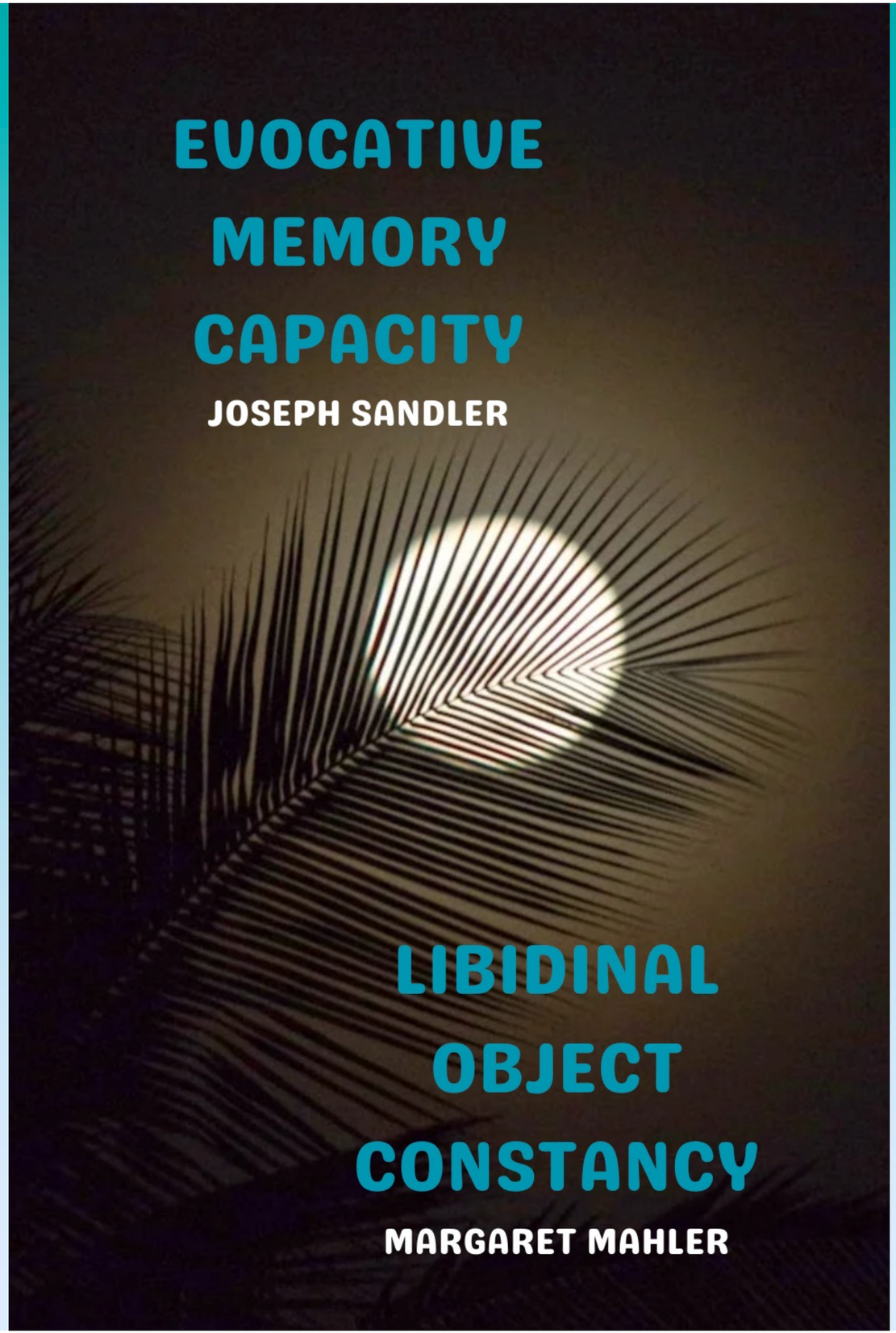
– AS A YOUNG, SENSITIVE CHILD –

SHE HAD BEEN BRIEFLY BLESSED
WITH THE CAPTIVATING EXPERIENCE
OF IDYLLIC, PEACEFUL MERGER
WITH A CAREGIVER WHO SEEMED
TO CHERISH HER

BUT THOSE PRECIOUS MOMENTS
ARE FOREVER LOST TO HER

– BECAUSE *YOU CAN'T GO HOME AGAIN* –


You Can't Go Home Again
BY
THOMAS WOLFE
AUTHOR OF "LOOK HOMEWARD, ANGEL," "OF TIME AND THE RIVER," AND "THE WEB AND THE ROCK"
You Can't Go Home Again


EVOCATIVE
MEMORY
CAPACITY
JOSEPH SANDLER
LIBIDINAL
OBJECT
CONSTANCY
MARGARET MAHLER

JOSEPH SANDLER (1950s – 1970s)
INTRODUCED THE CONCEPT OF "EVOCATIVE MEMORY"
– SOMETIMES REFERRED TO AS "EVOCATIVE MEMORY CAPACITY" –
IN CONNECTION WITH HIS INTEREST IN
"ACTUALIZATION OF PAST EXPERIENCE IN THE PRESENT"

MORE SPECIFICALLY
THE CAPACITY FOR EVOCATIVE MEMORY IS A "DEVELOPMENTAL ACHIEVEMENT"
THAT CAPTURES HOW EARLY RELATIONAL EXPERIENCES
CAN BE EVOKED IN THE HERE – AND – NOW OF THE THERAPEUTIC ENCOUNTER

IT ALLOWS THE PATIENT TO BRING PAST RELATIONAL PATTERNS
INTO CONSCIOUS AWARENESS
– PROVIDING A BRIDGE BETWEEN PAST AND PRESENT, MEMORY AND CURRENT EXPERIENCE –

SANDLER DESCRIBED EVOCATIVE MEMORY
AS THE CAPACITY TO "SUMMON TO MIND"
NOT ONLY A VISUAL IMAGE OF THE OBJECT
BUT ALSO THE FELT EMOTIONAL QUALITY
OF THE RELATIONSHIP WITH THE OBJECT
– A RE – EXPERIENCING OF THE OBJECT'S PRESENCE ALONG WITH ITS AFFECTIVE IMPACT –
– A BRINGING OF THOSE FEELINGS INTO CONSCIOUS AWARENESS
RATHER THAN BEING OVERWHELMED BY THEM –

THE CAPACITY FOR EVOCATIVE MEMORY
MAKES EARLY AFFECTIVE EXPERIENCES COHERENT AND INTEGRATED,
WHICH IN TURN SUPPORTS FONAGY'S "ADAPTIVE MENTALIZATION"
– ENABLING THE PATIENT TO THINK ABOUT SELF AND OTHERS IN WAYS THAT ARE
REFLECTIVE, EMOTIONALLY REGULATED, AND CONTEXTUALLY FLEXIBLE –

HEINZ HARTMANN (1950s)

– OFTEN REGARDED AS THE FATHER OF EGO PSYCHOLOGY –

WAS INTERESTED IN HOW THE EGO DEVELOPS

THE CAPACITY FOR STABLE INTERNALIZATION OF OBJECTS

HIS FOCUS WAS ON THE EGO'S "ADAPTIVE FUNCTIONS"

– INCLUDING REALITY TESTING AND AFFECT REGULATION –

TO THAT END

HE INTRODUCED THE CONCEPT OF "OBJECT CONSTANCY"

– AN ASPECT OF EGO DEVELOPMENT REFLECTING THE CHILD'S CAPACITY

TO MAINTAIN STABLE TIES TO OBJECTS,

DESPITE FRUSTRATION, AMBIVALENCE, OR SEPARATION –

MARGARET MAHLER (1960s – 1970s) LATER REFINED THIS CONCEPT,

DESCRIBING "LIBIDINAL OBJECT CONSTANCY"

AS A CRUCIAL "DEVELOPMENTAL ACHIEVEMENT"

– ONE THAT HIGHLIGHTS THE EMOTIONAL AND AFFECTIVE DIMENSION –

MORE SPECIFICALLY

SHE EMPHASIZED THE CHILD'S CAPACITY

TO SUSTAIN A STABLE, LOVING INTERNAL IMAGE OF THE CAREGIVER

– INFUSED WITH LIBIDINAL INVESTMENT –

EVEN IN THE CAREGIVER'S ABSENCE

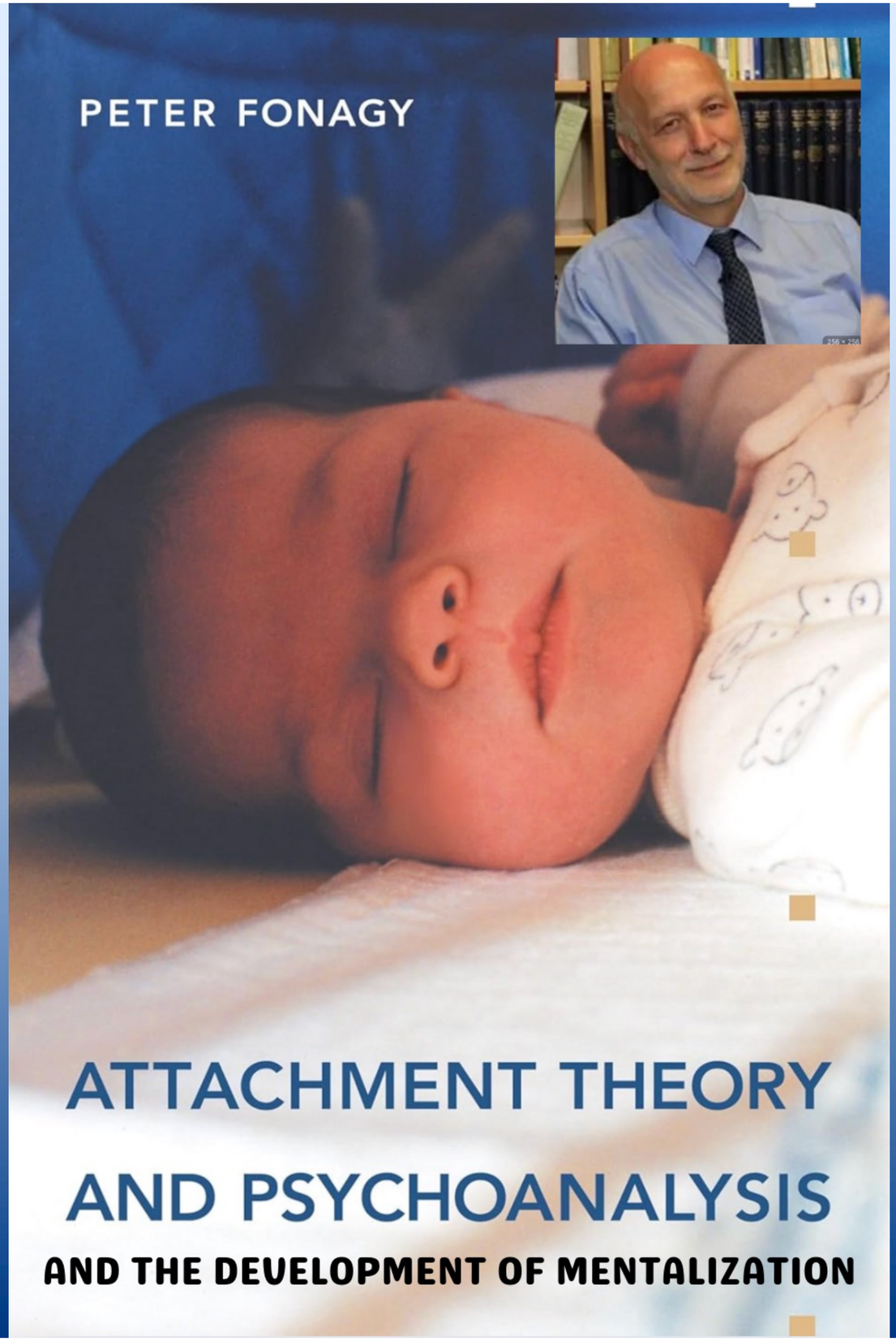
IN SUM

HEINZ HARTMANN – "OBJECT CONSTANCY" AS THE EGO'S "STRUCTURAL CAPACITY"

FOR STABILITY OF OBJECT REPRESENTATION

MARGARET MAHLER – "LIBIDINAL OBJECT CONSTANCY" AS THE EGO'S "EMOTIONAL ACHIEVEMENT"

OF ENDURING LOVE AND CONNECTION


PETER FONAGY
ATTACHMENT THEORY
AND PSYCHOANALYSIS
AND THE DEVELOPMENT OF MENTALIZATION

PETER FONAGY (1990s)
INTRODUCED THE CONCEPT OF "MENTALIZATION"
AND "MENTALIZING CAPACITY"

HIGHLY RESPONSIVE TO ENVIRONMENTAL INFLUENCES,
THIS CAPACITY IS A HARD – EARNED
"DEVELOPMENTAL ACHIEVEMENT"
THAT REFLECTS THE ABILITY
TO CREATE AND USE "MENTAL REPRESENTATIONS"
OF BOTH ONE'S OWN AND OTHERS' EMOTIONAL STATES
– FEELINGS, THOUGHTS, BELIEFS, DESIRES, INTENTIONS, MOTIVATIONS –

. . . AS WELL AS TO OBSERVE, UNDERSTAND, AND INTERPRET
ACTIONS AND BEHAVIORS
– BOTH ONE'S OWN AND OTHERS' –
AS EXPRESSIONS OF UNDERLYING MENTAL STATES

THE CONCEPT ALSO SPEAKS TO
THE "ADAPTIVE INTEGRATION" OF
COGNITIVE AWARENESS, AFFECTIVE EXPERIENCE,
AND BEHAVIORAL EXPRESSION
– SUPPORTING COHERENT AND FLEXIBLE FUNCTIONING ACROSS ALL THREE DOMAINS –
(THOUGHT, FEELING, AND ACTION)

IN ESSENCE

IT IS THE CAPACITY
TO IMAGINE, INTERPRET, AND MAKE MEANING
OF THE INNER WORLDS OF SELF AND OTHERS

– AND TO UNDERSTAND HOW THESE INTERNAL STATES SHAPE BEHAVIOR –

IN THEIR LANDMARK 2004 PAPER *"MENTALIZATION – BASED TREATMENT OF BPD"*

PETER FONAGY AND ANTHONY BATEMAN
OUTLINED A NEW APPROACH
TO TREATING PATIENTS WITH BORDERLINE FEATURES

THEIR MENTALIZATION – BASED TREATMENT (MBT)

– ROOTED IN "ATTACHMENT THEORY" –

IS INFORMED BY THE OBSERVATION
THAT PATIENTS WITH BPD
OFTEN LACK A RELIABLE CAPACITY TO MENTALIZE

– PRIMARILY BECAUSE OF INADEQUATE "ATTUNED MIRRORING"
IN THE EARLY ATTACHMENT RELATIONSHIP –

MORE SPECIFICALLY

SUCH PATIENTS LACK
A STABLE FOUNDATION FOR MENTALIZATION
BECAUSE THE EARLY CAREGIVER
HAD DIFFICULTY PROVIDING
“CONTINGENT AND MARKED AFFECTIVE DISPLAYS”
IN RESPONSE TO THE INFANT’S “SUBJECTIVE EXPERIENCE”

– IN OTHER WORDS, “ATTUNED RESPONSES”
THAT WERE BOTH “APPROPRIATE” AND “CLEARLY SIGNALED” –

THE “BIDIRECTIONAL NATURE OF MENTALIZING”
IS CENTRAL TO HOW PETER FONAGY AND HIS COLLEAGUES
– FONAGY, LUYTEN, & BATEMAN (2015), p. 381 –
“UNDERSTAND ITS DEVELOPMENTAL ORIGINS”
AND “FORMULATE THE TREATMENT AND TREATMENT TARGETS”
FOR THE PSYCHOTHERAPY OF PATIENTS WITH BPD

THEY WRITE –

“THE OBJECTIVE OF REACHING
A STATE OF IMPROVED MENTALIZING IN THE PATIENT
IS REACHED THROUGH AN INTERACTIONAL PROCESS
WHEREBY THE THERAPIST
MODELS THEIR OWN MENTALIZING CAPACITIES
AND DEMONSTRATES THEIR ABILITY TO MENTALIZE THE PATIENT.”

THEY ELABORATE –

“IN OTHER WORDS,
MENTALIZING AS AN END TARGET
IS ACHIEVED THROUGH THE EXPERIENCE
OF BEING EFFECTIVELY MENTALIZED;
IT IS AN IMPLICITLY PROCESSED EXPERIENCE
AS WELL AS A TARGET OF TREATMENT.”

IN MENTALIZATION – BASED TREATMENTS

THE THERAPIST WILL “MIRROR” THE PATIENT’S EMOTION

– BUT IN A SLIGHTLY EXAGGERATED OR CARICATURED WAY –

SO THAT THE PATIENT CAN RECOGNIZE IT
AS BOTH “REFLECTION” AND “MODELING”

– RATHER THAN THE CAREGIVER’S OWN EMOTION FULLY TAKING OVER –

REFLECTION – HERE IS YOUR FEELING – SEEN AND NAMED
MODELING – HERE IS HOW TO UNDERSTAND IT – STEP BY STEP

ORDINARILY

WHEN A PATIENT EXPERIENCES A LOSS

– WHETHER REAL OR MERELY PERCEIVED –

SHE MUST ULTIMATELY CONFRONT THE PAINFUL TRUTH

THAT SOMETHING SHE ONCE HAD IS NOW GONE

THIS "FACING OF THE TRUTH"

– AND THE EVOLUTION TOWARD SOBER, MATURE ACCEPTANCE –

IS AN ESSENTIAL PART OF THE GRIEVING PROCESS

INDEED

IF THE PATIENT IS EVER TO MOVE BEYOND HER EXPERIENCE OF BEREAVEMENT,

SHE MUST FACE

– AND ULTIMATELY ACCEPT –

THAT SOMETHING HAS CHANGED FOREVER

AS PART OF GENUINE GRIEVING

THE PATIENT WILL ADAPT BY TAKING IN THE "GOOD"

THAT HAD EXISTED PRIOR TO THE "LOSS"

– PRESERVING INTERNALLY THE ORIGINAL EXPERIENCE OF EXTERNAL GOODNESS –

IN THE SELF PSYCHOLOGICAL LITERATURE

THIS PROCESS IS REFERRED TO AS

"ADAPTIVE TRANSMUTING (OR STRUCTURE – BUILDING) INTERNALIZATION"

– AN INEVITABLE AND FELICITOUS ACCOMPANIMENT OF GENUINE GRIEVING –

– IT IS "ADAPTIVE" IN THAT IT ALLOWS THE PATIENT TO PRESERVE SOMETHING
SHE KNOWS WILL NO LONGER BE AVAILABLE IN THE EXTERNAL WORLD –

THE "CAPACITY TO GRIEVE" IS THEREFORE CENTRAL
TO THE RELINQUISHMENT OF "RELENTLESS HOPE"

AND IN ORDER TO GRIEVE EFFECTIVELY
THE PATIENT MUST HAVE THE "CAPACITY TO REMEMBER"
– THAT IS, EVOCATIVE MEMORY –
(WHICH PATIENTS WITH BORDERLINE DEFENSES HAVE NOT YET ESTABLISHED)

THIS ENABLES "EMPATHIC FAILURES" IN THE THERAPEUTIC RELATIONSHIP
– MOMENTS OF "DISRUPTED POSITIVE TRANSFERENCE" OR "DISILLUSIONMENT" –
TO BE WORKED THROUGH, GRIEVED, AND ULTIMATELY INTEGRATED

IN THE PROCESS
THE PATIENT WILL ADAPTIVELY INTERNALIZE
THE "GOOD – ENOUGH CAREGIVING"
THAT HAD ONCE EXISTED IN THE THERAPEUTIC RELATIONSHIP
– "EMPATHIC ATTUNEMENT" AND OTHER CAREGIVING SELFOBJECT FUNCTIONS –

AS STRUCTURAL DEFICITS ARE GRADUALLY REPAIRED,
THE PATIENT WILL DEVELOP THE CAPACITY TO BECOME
A "GOOD – ENOUGH CAREGIVER" UNTO HERSELF

HER RELENTLESS PURSUIT OF "PERFECT CAREGIVING" FROM THE OUTSIDE
WILL THEREBY BE TRANSFORMED INTO
THE CAPACITY TO PROVIDE "GOOD – ENOUGH CAREGIVING" FROM WITHIN
– AND WITH THAT, HER RELENTLESS HOPE CAN FINALLY BE RELINQUISHED –

BECAUSE OF THE VOLATILE, ERRATIC, AND DISORGANIZED CAREGIVING
TO WHICH PATIENTS WHO LATER DEVELOP BORDERLINE DEFENSES WERE ONCE EXPOSED,
THEY NEVER HAD THE CRITICALLY IMPORTANT OPPORTUNITY TO DEVELOP
"LIBIDINAL OBJECT CONSTANCY" / "EVOCATIVE MEMORY"
– THE ABILITY TO HOLD IN MIND, SIMULTANEOUSLY,
BOTH "GOOD" (LOVING) AND "BAD" (HATEFUL) FEELINGS ABOUT SIGNIFICANT OTHERS –

THIS INABILITY TO INTEGRATE BOTH
THE POSITIVE AND THE NEGATIVE ASPECTS OF OBJECTS
– AND OF THE SELF –
ALSO UNDERLIES THEIR WELL – KNOWN PATTERN
OF "DEFENSIVE SPLITTING" IN RELATIONSHIPS
– BE IT INTENTIONAL OR INADVERTENT –

IN SUM, AND AS WE SHALL SOON SEE,
THEIR TENUOUSLY ESTABLISHED "EVOCATIVE MEMORY CAPACITY"
CONTRIBUTES SIGNIFICANTLY TO THEIR IMPAIRED ABILITY
TO CONFRONT – AND GRIEVE – DISILLUSOINING REALITIES
– MOST ESPECIALLY, "EMPATHIC FAILURES" BY THE OBJECTS OF THEIR DESIRE –

IT IS THIS COMPROMISED CAPACITY TO GRIEVE
– AND THE RESULTING MISSED OPPORTUNITY
TO INTERNALIZE WHATEVER GOOD ONCE EXISTED,
THEREBY REPAIRING DEFICITS IN SELF – STRUCTURE, FOSTERING CAREGIVING CAPACITY,
AND QUENCHING EMOTIONAL THIRST –
THAT MAKES IT PARTICULARLY DIFFICULT FOR THESE PATIENTS
TO RELINQUISH THEIR RELENTLESS HOPE

IN SUM,

PATIENTS WITH BORDERLINE FEATURES
CANNOT YET GRIEVE EFFECTIVELY

LACKING SOLIDLY ESTABLISHED EVOCATIVE MEMORY AND MENTALIZING CAPACITY,

THEY CANNOT HOLD IN MIND THE "MEMORY"
OF PAST "GOOD" IN THE FACE OF PRESENT "BAD"

WITHOUT EVOCATIVE MEMORY,

THERE IS NO INNER STOREHOUSE OF "GOOD"
TO DRAW UPON IN MOMENTS OF RUPTURE

WITHOUT MENTALIZING,

THERE IS NO CAPACITY TO HOLD MULTIPLE TRUTHS AT ONCE
– TO IMAGINE AMBIVALENCE OR COMPLEXITY –

AS A RESULT,

THE PSYCHE DEFAULTS TO SPLITTING
– THE ONLY WAY TO "MANAGE" WHAT FEELS OTHERWISE UNMANAGEABLE –

IN OTHER WORDS,

THE ABSENCE OF EVOCATIVE MEMORY AND MENTALIZATION
LEAVES PATIENTS WITH BORDERLINE FEATURES
VULNERABLE TO THE TYRANNY OF THE MOMENT
– WHERE PRESENT PAIN ECLIPSES PAST GOODNESS
AND DEFENSIVE SPLITTING SUBSTITUTES FOR ADAPTIVE INTEGRATION –


DEVELOPMENT
OF
EVOCATIVE
MEMORY
CAPACITY
SO THAT PAST “GOOD” CAN BE REMEMBERED
IN THE FACE OF PRESENT “BAD”

I WOULD LIKE NOW TO EXPLORE HOW WE

– AS THERAPISTS –

CAN FACILITATE THE PROCESS BY WHICH

PATIENTS HELD CAPTIVE BY BORDERLINE DEFENSES

– PATIENTS WHO THEREFORE STRUGGLE TO REMEMBER

PAST GRATIFICATION IN THE FACE OF PRESENT DISAPPOINTMENT –

CAN BEGIN TO ACQUIRE

“EVOCATIVE MEMORY CAPACITY”

– AND, EVENTUALLY, “MENTALIZING CAPACITY” –

IT IS THIS EMERGENT CAPACITY

THAT WILL ENABLE SUCH PATIENTS

TO GRIEVE DISAPPOINTMENTS

ONCE FELT UNGRIEVABLE

. . . AND GRADUALLY TO SHIFT

FROM “RELENTLESS PURSUIT OF “THE UNATTAINABLE”

TO “FULLER ACCEPTANCE” OF “WHAT IS”

. . . AND SATISFACTION WITH WHAT IS “GOOD – ENOUGH” –

(THE “APPROXIMATELY – PERFECT”)

THE DEVELOPMENT OF SELF – STRUCTURE

– THE GRADUAL EMERGENCE OF CAREGIVING CAPACITY –

TYPICALLY DEPENDS UPON A PROLONGED PROCESS

OF WORKING THROUGH

“FRUSTRATED NARCISSISTIC NEED” / “DISILLUSIONMENT”

– THE CHLD’S LONGING FOR A “MIRRORING SELFOBJECT”

TO BATHE THE “GRANDIOSE SELF” IN ADMIRING LIGHT,

OR FOR AN “IDEALIZED PARENT IMAGO”

WITH WHOSE CALM STRENGTH

THE CHILD CAN SAFELY FUSE, IF ONLY IN FANTASY –

BUT FOR PATIENTS WITH BORDERLINE DYNAMICS

– WHOSE FRAGILE EVOCATIVE MEMORY SERIOUSLY COMPROMISES

THEIR CAPACITY TO GRIEVE –

THE DEVELOPMENT OF SELF – STRUCTURE

– SUCH THAT “GOOD – ENOUGH CAREGIVING” CAN EVENTUALLY BE PROVIDED FROM WITHIN

RATHER THAN “PURSUED RELENTLESSLY” FROM WITHOUT –

IS NOT MERELY A MATTER

OF WORKING THROUGH “FRUSTRATED NARCISSISTIC NEED”

IT REQUIRES SOMETHING ALTOGETHER DIFFERENT . . .


THE THERAPIST AS A
“CONTAINING
SELFOBJECT”
– NECESSARY IF THE RELATIONSHIP
IS TO CONTINUE –
WHAT THE PATIENT WITH BPD MOST NEEDS IS “EXTERNAL CONTAINMENT”

THE PATIENT'S COLLAPSE INTO SPLITTING AND "ACTING OUT"

FOR PATIENTS WITH
BORDERLINE VULNERABILITY AND DEFENSIVE SPLITTING,
WHEN DISAPPOINTED BY THE THERAPIST,
THE ONCE "ALL – GOOD," GRATIFYING OBJECT
IS INSTEAD EXPERIENCED
AS AN "ALL – BAD," FRUSTRATING OBJECT

UNABLE TO SUSTAIN AMBIVALENCE,
THE PATIENT REVERTS TO
THE PRE – AMBIVALENT MODE OF PRIMITIVE SPLITTING
– HATE FOR THE OBJECT INSTANTLY REPLACING LOVE –

THE THERAPIST
– ONCE FELT TO BE NARCISSISTICALLY SUSTAINING –
IS NOW EXPERIENCED AS HAVING BEEN LOST
– BOTH EXTERNALLY AND INTERNALLY –
LEAVING THE PATIENT OVERWHELMED BY RAGE, PANIC,
AND A TERRIFYING SENSE OF ALONENESS

IN DESPERATION
SHE BECOMES PRONE TO "ENACTING" HER OUTRAGE
– IN A VARIETY OF INDULGENT AND DESTRUCTIVE WAYS –

THE THERAPEUTIC IMPERATIVE: EXTERNAL CONTAINMENT

WHAT IS THEREFORE MOST NEEDED
– AT LEAST INITIALLY –
IS "EXTERNAL CONTAINMENT" BY THE THERAPIST

BY "CONTAINMENT"
I MEAN "HOLDING AND MANAGING"
THE PATIENT'S TENDENCY TO "ACT OUT"
IN RESPONSE TO
HER DIFFICULTY TOLERATING INTENSE RELATIONAL DISAPPOINTMENT

IN THE AFTERMATH OF SUCH DISAPPOINTMENT
THE PATIENT IS OFTEN TEMPTED TO SEVER HER TIE
TO THE DISILLUSIONING OBJECT
– THE THERAPIST –

HER INABILITY TO HANDLE RELATIONAL DISAPPOINTMENT
– ALONG WITH HER SENSE OF OUTRAGE
AND FRUSTRATED ENTITLEMENT AT HAVING BEEN THWARTED –
FUELS HER IMPULSE TO "DESTROY"
AND TO "FLEE" FROM WHAT HAS BECOME INTOLERABLY PAINFUL

IF THE THERAPEUTIC RELATIONSHP IS TO SURVIVE,
THE THERAPIST MUST SET FIRM,
BUT CARING AND NONPUNITIVE, LIMITS
– ALWAYS AGAINST THE BACKDROP
OF DEMONSTRATING INDESTRUCTIBILITY
IN THE FACE OF THE PATIENT'S ATTEMPTS TO "ANNIHILATE" HER –

THE THERAPIST

– THROUGH BOTH VERBAL AND NONVERBAL MEANS –

MUST PROVIDE "EXTERNAL CONTAINMENT"

OF THE PATIENT'S IMPULSE TO "ACT OUT"

BECAUSE THE PATIENT SUFFERS FROM

A STRUCTURAL SELF – DEFICIT

– NAMELY, AN IMPAIRED CAPACITY TO BE SELF – CONTAINING –

SHE CANNOT YET PROVIDE

SUCH CONTAINMENT FOR HERSELF

THIS "SELF – DEFICIT"

– ALONG WITH COMPROMISED EVOCATIVE MEMORY AND DEFENSIVE SPLITTING –

IS A HALLMARK OF BORDERLINE VULNERABILITY

THE HEART OF TREATMENT

THEREFORE LIES IN THE THERAPIST'S

STEADFAST PRESERVATION

OF THE RELATIONSHIP

AND CONTAINMENT OF

THE PATIENT'S IMPULSIVE, RAGEFUL,

AND DESTRUCTIVE "ACTING OUT"

IN HER ROLE AS CONTAINING SELFOBJECT,

THE THERAPIST THEREFORE SERVES AS A DETERRENT

– NEITHER WITHDRAWING NOR RETALIATING –

(EVEN IF, AT TIMES, SHE MIGHT BE SORELY TEMPTED TO DO SO)

NO LONGER RELEVANT HERE IS "OPTIMAL FRUSTRATION"

– LEAVING SPACE FOR THE "RESOURCED" PATIENT TO WORK THINGS OUT INTERNALLY –

RATHER,

WHEN DEALING WITH PATIENTS WHO LACK THE CAPACITY TO GRIEVE,

THE THERAPIST MUST "DIRECTLY GRATIFY"

THE PATIENT'S "NEED FOR CONTAINMENT"

– NOT WITHHOLD IT UNDER THE GUISE OF PROVIDING

"GROWTH – INCENTIVIZING OPTIMAL FRUSTRATION" –

. . . BECAUSE FOR PATIENTS WITH BORDERLINE VULNERABILITY,

THERE IS NO SUCH THING AS "OPTIMAL FRUSTRATION"

EVERY DISAPPOINTMENT, OF WHATEVER MAGNITUDE,

IS EXPERIENCED AS "TRAUMATIC"

– AS ONE THAT IS UNABLE TO BE GRIEVED, UNABLE TO BE MASTERED –

MISGUIDED – HOWEVER WELL – INTENTIONED – EFFORTS

TO SUPPLY "OPTIMAL FRUSTRATION"

WILL THEREFORE BE NO GIFT AT ALL

– AND, IF ANYTHING, WILL SIMPLY SERVE TO RETRAUMATIZE –

FOR PATIENTS WITH BPD

EVERY DISILLUSIONMENT BECOMES A TRAUMATIC ONE

CONTAINMENT IS THE GIFT


CONTAINING
STATEMENTS

THE THERAPIST MUST DO EVERYTHING SHE CAN
TO KEEP THESE VULNERABLE PATIENTS
ALIVE AND ENGAGED IN THE TREATMENT

I WOULD LIKE TO SUGGEST THAT THE SELFOBJECT THERAPIST
USE WHAT I CALL A "CONTAINING STATEMENT"
– TO HELP LIMIT THE PATIENT'S TENDENCY TO ACT OUT –

LET ME CLARIFY WHAT I MEAN

THE "CONTAINING STATEMENT" IS A PARTICULAR KIND
– OF PSYCHOTHERAPEUTIC INTERVENTION –
THAT PROVES ESPECIALLY EFFECTIVE WITH SUCH PATIENTS
– ALTHOUGH IT MIGHT BENEFIT OTHERS AS WELL –

BY WAY OF EXAMPLE
SUPPOSE THE END OF THE HOUR HAS ARRIVED,
AND THE PATIENT REMAINS SEATED, UNMOVING

HOW MIGHT THE THERAPIST HELP THE PATIENT LEAVE THE OFFICE
– WITHOUT SHAMING HER AND WITHOUT CREATING A RUPTURE TOO TERRIBLE TO BEAR –

LET US IMAGINE THAT THE THERAPIST
HAS BEEN READING HER "SELF PSYCHOLOGY"
– AND THEREFORE DECIDES TO RESPOND EMPATHICALLY –

AND SO THE THERAPIST SAYS –
"YOU WOULD WISH THAT YOU COULD STAY"

THIS IS CERTAINLY A NICE THING TO SAY

THE PATIENT

– FEELING BOTH UNDERSTOOD AND LEGITIMIZED –

NODS IN AGREEMENT

– BUT REMAINS SEATED –

THE THERAPIST THEN RECALLS THE ADVICE ABOUT
THE IMPORTANCE OF "SETTING FIRM LIMITS"
WITH PATIENTS WHO RELY ON BORDERLINE DEFENSES

– THAT IS, THE VALUE OF PROVIDING EXTERNAL STRUCTURE
TO COMPENSATE FOR THE PATIENT'S LACK OF INTERNAL STRUCTURE
AND HER IMPAIRED CAPACITY FOR SELF – CONTAINMENT –

AND SO THE THERAPIST SAYS –

"I'M SORRY, BUT OUR TIME IS UP; AND WE DO HAVE TO STOP."

. . . DELIVERED WITH A CERTAIN KIND OF NO – NONSENSE CLARITY

THE PATIENT, NOW ENRAGED, JUST SITS

– ROOTED TO THE SPOT –

MY PROPOSAL, THEN, IS USE OF A "CONTAINING STATEMENT"

A PARTICULAR KIND OF INTERVENTION IN WHICH THE THERAPIST BOTH

"SUPPORTS" BY RESONATING EMPATHICALLY

– WITH THE PATIENT'S AFFECT –

AND "CHALLENGES" BY REMINDING THE PATIENT

– OF WHAT, DEEP WITHIN (ALBEIT RELUCTANTLY),
THE PATIENT DOES INDEED ALREADY KNOW TO BE TRUE –

AND SO THE THERAPIST SAYS –

"PERHAPS YOU WOULD WISH THAT YOU COULD STAY;
BUT, AS YOU KNOW, OUR TIME IS UP,
AND WE DO HAVE TO STOP."

THIS CONTAINING STATEMENT
FIRST RESONATES WITH WHAT THE PATIENT
IS EXPERIENCING IN THE MOMENT
– NAMELY, A DESIRE TO STAY –
AND THEN REMINDS THE PATIENT
OF THE REALITY OF THE SITUATION
– NAMELY, HER TIME IS UP –

WE FIRST "SUPPORT"
BY RESONATING EMPATHICALLY
– THEREBY PROVIDING "UNDERSTANDING" –
AND THEN WE "CHALLENGE"
BY REMINDING THE PATIENT OF REALITY
– THEREBY PROVIDING "CONTAINMENT," "RESTRAINT," AND "LIMITS" –

BY RESONATING WITH THE AFFECT
THE PATIENT IS EXPERIENCING IN THE MOMENT,
WE ARE ATTEMPTING TO ENGAGE HER "EXPERIENCING EGO"

AND BY REMINDING HER OF THE REALITY OF THE SITUATION,
WE ARE ATTEMPTING TO ENGAGE HER "OBERVING EGO"

WHEN WE SAY –

“BUT, AS YOU KNOW, OUR TIME IS UP,
AND WE DO NEED TO STOP.”

NOTICE THAT WE HAVE STRATEGICALLY INSERTED THE PHRASE
“AS YOU KNOW”
(SOMETIMES “AS YOU AND I BOTH KNOW”)
INTO THE SECOND HALF OF THE “CONTAINING STATEMENT”

WE ARE DETERMINED TO MOBILIZE HER OBSERVING EGO
– AND TO PROMOTE DEVELOPMENT OF HER MENTALIZING CAPACITY –

BY HIGHLIGHTING WHAT SHE KNOWS, AT HER CORE, TO BE HER ACCOUNTABILITY,
WE ARE CHALLENGING HER
TO TAKE RESPONSIBILITY FOR HER ACTIONS

WE ARE INSISTING THAT SHE ACKNOWLEDGE
THE “LOCUS OF CONTROL” AS AN INTERNAL ONE

BY EMPHASIZING THIS ELEMENT OF “CHOICE,”
WE ARE INTENT UPON EMPOWERING HER

“PERHAPS YOU WOULD WISH THAT YOU COULD STAY;
BUT, AS YOU KNOW, OUR TIME IS UP, AND WE DO HAVE TO STOP.”

“DUAL AWARENESS” IS BEING FOSTERED
– WHEN THE PATIENT IS BEING ASKED TO DIRECT HER ATTENTION –
TO WHAT SHE IS EXPERIENCING IN THE MOMENT
– “WOULD WISH” –

– AT THE SAME TIME THAT SHE IS BEING ENCOURAGED –
TO STEP BACK FROM THE IMMEDIACY OF THAT EXPERIENCE
IN ORDER TO DETACH HERSELF
FROM THE INTENSITY OF THE MOMENT, GAIN SOME DISTANCE,
AND RECOVER A REALITY – BASED PERSPECTIVE
– “BUT AS YOU KNOW” –

IN THE PSYCHOANALYTIC LITERATURE
THIS DISTINCTION BETWEEN
“EXPERIENCING” SOMETHING AND “OBSERVING” IT
IS DESCRIBED AS A (HEALTHY) “SPLIT IN THE EGO” (OR IN “THE SELF”)

BETWEEN THE EXPERIENCING / PARTICIPATING EGO
“WOULD WISH”
AND THE OBSERVING / REFLECTING EGO
“BUT AS YOU KNOW”

RICHARD STERBA (1994); LESTON HAVENS (1976)

PARENTHETICALLY
ALL THE OPTIMALLY STRESSFUL, GROWTH – INCENTIVIZING “PROTOTYPICAL INTERVENTIONS”
FEATURED IN THE STARK METHOD of PSYCHODYNAMIC SYNERGY
ARE STRATEGICALLY DESIGNED TO SUPPORT THE PATIENT’S “DUAL AWARENESS”

ENGAGING BOTH THE “ANALYTIC WISDOM” OF THE (LEFT – BRAIN) “OBSERVING EGO” and THE “EMOTIONAL – RELATIONAL WISDOM” OF THE (RIGHT – BRAIN) “EXPERIENCING EGO”

THE THERAPIST

– HERE IN HER CAPACITY AS A "CONTAINING SELFOBJECT" –

WILL REPEATEDLY OFFER THE PATIENT

THESE "CONTAINING STATEMENTS"

– INTERVENTIONS STRATEGICALLY CRAFTED TO PROVIDE "CONTAINMENT"
BY DELIVERING JUST THE RIGHT BALANCE OF SUPPORT AND CHALLENGE –

"WHEN YOU GET ANGRY LIKE THIS, YOU THINK ABOUT TAKING FLIGHT;
BUT WE BOTH KNOW THAT SOMEDAY YOU'RE GOING TO HAVE TO STOP RUNNING."

THESE STATEMENTS ARE PURPOSEFULLY CONSTRUCTED TO GENERATE

– DESTABILIZING INTERNAL TENSION AND HOMEOSTATIC IMBALANCE –

BY WEAVING TOGETHER

ANXIETY – ASSUAGING SUPPORT

– RESONATING WITH THE PATIENT'S "FEELINGS" –

AND ANXIETY – PROVOKING CHALLENGE

– CALLING HER BACK TO WHAT SHE KNOWS, HOWEVER RELUCANTLY, TO BE TRUE –

"YOU'RE HATING ME RIGHT NOW AND THINKING ABOUT KILLING YOURSELF OR BREAKING OFF TREATMENT; BUT YOU AND I BOTH KNOW THAT IF YOU'RE EVER GOING TO UNDERSTAND WHY YOU HAVE SUCH TROUBLE GETTING CLOSE TO PEOPLE, THEN SOMEDAY YOU'RE GOING TO HAVE TO SLOW DOWN AND GIVE YOURSELF A CHANCE TO FIGURE OUT WHAT KEEPS GOING WRONG FOR YOU IN YOUR RELATIONSHIPS."

"YOU'D BEEN FEELING SO GOOD ABOUT OUR WORK, UNDERSTOOD IN A WAY THAT YOU'D NEVER BEFORE FELT, AND NOW YOU'RE FEELING THAT I DON'T KNOW YOU AT ALL AND THAT I DON'T CARE. BUT WE BOTH KNOW THAT IF I REALLY DIDN'T CARE ABOUT YOU, THEN I WOULDN'T HAVE BOTHERED TO MAKE MYSELF AVAILABLE FOR THIS SUNDAY MORNING APPIONTMENT."

ADDITIONAL EXAMPLES OF

OPTIMALLY STRESSFUL, GROWTH – INCENTIVIZING "CONTAINING STATEMENTS"

THAT FIRST "SUPPORT" BY

– RESONATING EMPATHICALLY WITH WHAT THE PATIENT IS FEELING –

AND THEN "CHALLENGE" BY

– REMINDING HER (GENTLY BUT FIRMLY)
OF WHAT BOTH SHE AND THE THERAPIST
RECOGNIZE AS THE GROUND THE PATIENT IS STANDING ON –

"YOU THINK ALL THE TIME ABOUT KILLING YOURSELF TO ESCAPE FROM THE PAIN;
BUT YOU KNOW THAT IF YOU DID THAT, YOUR KIDS WOULD NEVER FORGIVE YOU."

"WE KNOW THAT YOU'RE IN DEEP, DEEP PAIN RIGHT NOW AND WISHING THAT YOU WERE DEAD; BUT YOU AND I BOTH KNOW THAT, IF YOU KILLED YOURSELF, THEN YOUR KIDS (WHOM YOU LOVE DEEPLY AND WOULD NEVER WANT TO HURT), YOUR KIDS WOULD NEVER GET OVER IT."

"YOU JUST CAN'T GET RID OF THIS CONVICTION THAT IF YOU FEEL HURT BY ME, THEN YOU GET TO DO ANYTHING YOU WANT, INCLUDING BREAKING THE RULES, WHICH YOU AND I BOTH KNOW WE NEED TO HAVE IN ORDER FOR OUR RELATIONSHIP TO CONTINUE."

"YOU JUST CAN'T GET RID OF THIS IDEA THAT WHEN YOU FEEL HURT BY ME, YOU ARE ALLOWED TO RETALIATE – EVEN THOUGH YOU KNOW THAT SUCH BEHAVIORS ARE DESTRUCTIVE TO OUR RELATIONSHIP AND TO THE BOND THAT WE HAVE WORKED SO HARD TO DEVELOP."


IT IS THE THERAPIST'S
EXTERNAL PROVISION
OF CONTAINMENT
THAT ALLOWS
THE RELATIONSHIP
TO CONTINUE

LET US NOW CONSIDER
THE SCENARIO
OF A PATIENT WITH BORDERLINE DYNAMICS
WHO IS CONTINUOUSLY
THREATENING SUICIDE
YET EQUALLY INSISTENT
THAT SHE WILL NEVER GO
– WILLINGLY –
INTO A MENTAL HOSPITAL

DOES THAT PUT YOU IN A BIND?

ABSOLUTELY NOT!

THE BIND IS NOT YOURS –
THE BIND (OR MORE ACCURATELY)
THE "CHOICE" BELONGS TO THE PATIENT

YOU CAN THEREFORE OFFER HER
THE FOLLOWING
"SUICIDE CONTRACT"
– A THERAPEUTIC INTERVENTION THAT CONTAINS, DIGNIFIES, AND EMPOWERS –

YOU TELL THE PATIENT THAT SHE IS WELCOME TO SPEAK
OF HER DESPAIR, HER HOPELESSNESS, HER LONELINESS,
HER OUTRAGED DISAPPOINTMENT, HER FURY AT YOU –
FOR NOT UNDERSTANDING,
FOR NOT APPRECIATING JUST HOW MUCH SHE IS SUFFERING,
FOR NOT MAKING HER BETTER,
AND SO ON, AND SO FORTH

BUT FOR HER TO KNOW THAT, FROM HERE ON OUT,
IF SHE EVER SHARES WITH YOU ANYTHING AT ALL
THAT SOUNDS TO YOU AS IF
SHE MIGHT ACTUALLY HARM HERSELF,
THEN YOU WILL TAKE THAT AS HER WAY
OF LETTING YOU KNOW
THAT SHE NEEDS SOME FORM OF EXTERNAL CONTAINMENT

AGAIN, IF SHE GIVES ANY INDICATION WHATSOEVER
THAT SHE IS EVEN PLAYING WITH THE IDEA OF HURTING – OR KILLING – HERSELF,
THEN SHE IS TO UNDERSTAND THAT YOU WILL TAKE THAT
AS YOUR CUE TO TAKE ACTION

AND YOU WILL DO SO BY INSISTING THAT
– BEFORE SHE CAN RETURN TO TREATMENT WITH YOU –
SHE WILL HAVE TO PRESENT HERSELF TO
A PSYCHIATRIC EMERGENCY ROOM,
TO BE EVALUATED FOR HER SUICIDALITY

YOUR VERY CLEAR MESSAGE TO THE PATIENT IS THAT –

IF YOU TALK ABOUT SUICIDE, OR SAY ANYTHING AT ALL
THAT MAKES ME THINK YOU MIGHT EVEN BE VAGUELY CONSIDERING
HARMING YOURSELF IN ANY WAY WHATSOEVER,
THEN I WILL UNDERSTAND THAT TO BE A SIGNAL FOR ME
– THAT YOU ARE NEEDING ME TO DO SOMETHING –
– THAT YOU ARE COMMUNICATING A NEED FOR ME TO PROVIDE
YOU WITH A CLEAR, STRUCTURED BOUNDARY,
TO CONTAIN FROM THE OUTSIDE WHAT FEELS UNCONTAINABLE FROM WITHIN –

IF THE PATIENT THEN RETORTS –
“WELL, IF THAT HAPPENS, I’LL JUST TELL THE DOCTORS
AT THE HOSPITAL THAT I’M NOT REALLY SUICIDAL.”

THEN YOU GET TO SAY –
“NO PROBLEM. IN ANY EVENT,
YOU WON’T BE ABLE
TO RETURN YOUR TREATMENT WITH ME
UNTIL YOU’VE BEEN EVALUATED
FOR YOUR SUICIDALITY.”

INTERESTINGLY (AND PROBABLY NOT SURPRISINGLY)
PATIENTS USUALLY “TEST” THIS
(NON – NEGOTIABLE) LIMIT ONLY ONCE
– IF EVEN THAT OFTEN –

THE THERAPIST IS NOT ONLY PROVIDING "CONTAINMENT"
BUT ALSO OFFERING THE PATIENT AN OPPORTUNITY
TO EXPERIENCE "CAUSE AND EFFECT" FIRSTHAND

INDEED
AN ESSENTIAL PART OF MENTALIZATION
IS LEARNING ABOUT CONSEQUENCES
– COMING TO UNDERSTAND THAT "PROVOCATIVE ACTIONS"
WILL HAVE "PREDICTABLE OUTCOMES" –

THIS INVOLVES FOSTERING AN EMPOWERING SENSE OF RESPONSIBILITY,
– GUIDING THE PATIENT TO RECOGNIZE THAT CERTAIN BEHAVIORS
WILL INEVITABLY PRODUCE RESULTS –

THE THERAPIST IS EMPHASIZING "AGENCY"
– HELPING THE PATIENT SEE THE IMPACT OF HER ACTIONS ON OTHERS –
(ALIGNING WITH FONAGY'S CONCEPT OF "MENTALIZING CAPACITY")

THIS IS CENTRAL TO FOSTERING THE PATIENT'S UNDERSTANDING
OF HOW HER BEHAVIORS ARE AFFECTING
BOTH HERSELF AND THOSE AROUND HER

TO REINFORCE THIS LESSON,
THE THERAPIST MIGHT OFFER A "CONTAINING STATEMENT," SUCH AS –
"ALTHOUGH YOU MIGHT WISH YOU COULD KEEP TALKING
ABOUT SUICIDE AND YOUR DESIRE TO HARM YOURSELF,
THE REALITY IS THAT IF YOU DO, I WILL TAKE IT SERIOUSLY
AND TAKE THE NECESSARY STEPS TO INTERVENE."

"CONTAINING STATEMENTS" ALWAYS JUXTAPOSE GROWTH – INCENTIVIZING "SUPPORT" WITH "CHALLENGE"

– BOTH ARE HELD IN TENSION, SIDE BY SIDE –

FIRST, WE PROVIDE "HOLDING"

– ENABLING THE PATIENT TO "FEEL UNDERSTOOD" –

THEN, WE INVITE (OR DEMAND) "ACCOUNTABILITY"

– RESPECTFULLY RETURNING AGENCY TO HER –

"WHEN SOMEONE LETS YOU DOWN AS I HAVE,
YOUR TEMPTATION IS TO FLEE;
THOUGH WE BOTH KNOW THAT IF YOU EVER WANT TO HAVE A RELATIONSHIP,
THEN SOMEDAY YOU'RE GOING TO HAVE TO STOP RUNNING –
SO THAT YOU CAN FIGURE OUT WHY YOU'RE SO UNFORGIVING,
WHY YOU'RE SO RELENTLESS,
AND WHAT HAPPENS INSIDE YOU WHEN SOMEONE DISAPPOINTS YOU."

"WHEN YOU'RE FEELING THIS FRUSTRATED AND ANGRY,
YOUR FIRST IMPULSE IS TO LASH OUT.
BUT WE BOTH KNOW THAT IF YOU'RE EVER TO GET BETTER,
THEN SOMEDAY YOU'LL NEED TO LEARN TO PUT INTO WORDS
HOW AWFUL YOU FEEL INSTEAD OF ACTING IT OUT
IN SUCH DESPERATE, DESTRUCTIVE, AND INDULGENT WAYS."

THE GOAL IS ALWAYS TO STRIKE A DELICATE BALANCE BETWEEN "EMPATHIC RESONANCE" AND "DEVELOPMENTAL DEMAND"

– BETWEEN "HOLDING" AND "ACCOUNTABILITY" / "EMPOWERMENT" –

CONTAINING STATEMENTS

STRIKE AN “OPTIMALLY STRESSFUL” BALANCE

BETWEEN “EMPATHIC RESONANCE”

AND “DEVELOPMENTAL DEMAND”

– BETWEEN “HOLDING” AND “ACCOUNTABILITY” –

EXAMPLES OF "CONTAINING STATEMENTS"

– THAT JUXTAPOSE "SAFE HARBOR" WITH "DEVELOPMENTAL EXPECTATION" –

**"GIVEN THAT YOU NEVER REALLY FELT SUPPORTED BY YOUR MOTHER,
BUT OF COURSE YOU NOW DESPERATELY WANT THAT KIND OF SUPPORT FROM ME.
I HAVE TRIED HARD TO GIVE YOU THAT SUPPORT,
ALTHOUGH THERE ARE TIMES WHEN I HAVE INADVERTENTLY LET YOU DOWN.
WE BOTH KNOW, HOWEVER, THAT IF OUR RELATIONSHIP IS TO SURVIVE,
YOU'RE GOING TO HAVE TO LEARN TO FORGIVE ME
WHEN I DON'T ALWAYS GET IT JUST RIGHT."**

**"WHEN I KEEP LETTING YOU DOWN LIKE THIS,
YOU WONDER IF YOU'LL EVER BE ABLE TO TRUST ME AGAIN,
THOUGH WE BOTH KNOW THAT UNLESS YOU'RE WILLING
TO DO THE WORK OF TRYING TO UNDERSTAND WHAT HAPPENS FOR YOU
WHEN YOU DON'T GET EXACTLY WHAT YOU WANT,
THEN YOU'LL NEVER GET ANY BETTER."**

**"AT TIMES LIKE THIS YOU CAN'T REMEMBER
EVER HAVING VALUED ME OR THE THERAPY
AND YOU THINK ABOUT STOPPING TREATMENT.
BUT WE BOTH KNOW THAT IF YOU'RE EVER GOING
TO GET ANYWHERE IN YOUR LIFE
OR BE IN A POSITION TO PURSUE ANY OF YOUR DREAMS,
THEN EVENTUALLY YOU'RE GOING TO HAVE TO
GIVE UP YOUR INVESTMENT IN SEEING YOURSELF
AS ALWAYS THE MISUNDERSTOOD VICTIM."**

INTEGRATION STATEMENTS

LET ME NOW INTRODUCE THE "INTEGRATION STATEMENT"

– A POWERFULLY IMPACTFUL INTERVENTION,
PARTICULARLY RELEVANT FOR PATIENTS WITH LIMITED CAPACITY
TO INTEGRATE THE "GOOD" AND THE "BAD" ASPECTS OF THEIR EXPERIENCE
AND WHO, WHEN OVERWHELMED BY UNBEARABLE AFFECT,
REGRESS TO "DEFENSIVE SPLITTING" –

AN "INTEGRATION STATEMENT" CAN BE MASTERFULLY EMPLOYED IN THE AFTERMATH OF A THERAPEUTIC RUPTURE

IT IS MOST EFFECTIVE IN THOSE MOMENTS

– WHEN THE PATIENT FEELS SO DEVASTATED, BETRAYED, AND ENRAGED –
THAT SHE SIMPLY CANNOT REMEMBER
EVER HAVING FELT GOOD ABOUT THE THERAPIST

THE THERAPIST ENTERS INTO THE PATIENT'S
INTERNAL EXPERIENCE OF OUTRAGED DEVASTATION
COMING TO APPRECIATE THAT
THE "GOOD" OF THE PAST CANNOT
– IN MOMENTS OF RAGEFUL DISAPPOINTMENT –
BE "REMEMBERED" / "EVOKED" BY THE PATIENT

NOR CAN "HOPE" FOR THE FUTURE
– IN THOSE SAME MOMENTS –
BE "IMAGINED" / "ENVISIONED"

“INTEGRATION STATEMENTS”

– SUPPORT THE CONTAINMENT AND MEANING – MAKING OF “CONFLICTED FEELINGS” –

THEY ARE STRATEGICALLY DESIGNED TO FOSTER “EMOTIONAL INTEGRATION”

– THE CAPACITY TO BEAR THE TENSION OF MIXED FEELINGS
AND TO TOLERATE THE NUANCE, DISSONANCE,
AND INEVITABLE AMBIGUITY OF EMOTIONAL COMPLEXITY –

THESE INTERVENTIONS ARE USEFUL
NOT ONLY FOR PATIENTS WHO ROUTINELY “DEFEND” THROUGH “SPLITTING”
BUT, MORE BROADLY, FOR PATIENTS WHO STRUGGLE TO HOLD IN MIND

– SIMULTANEOUSLY –

BOTH THE “TENDER” AND THE “WOUNDED” ASPECTS OF EXPERIENCE

– WITH RESPECT TO SELF AND OTHERS –

IN OTHER WORDS

“INTEGRATION STATEMENTS” ARE PARTICULARLY EFFECTIVE FOR PATIENTS
WITH FRAGILE “EVOCATIVE MEMORY CAPACITY”

– THE “REPRESENTATIONAL” / “COGNITIVE” ABILITY TO RECALL
PAST RELATIONAL EXPERIENCES AND ASSOCIATED FEELINGS –

AND WHOSE LOVE FOR SELF AND OTHERS IS ALSO TENUOUSLY HELD
BECAUSE OF PRECARIOUS “LIBIDINAL OBJECT CONSTANCY”

– THE “AFFECTIVE” / “EMOTIONAL” ABILITY TO SUSTAIN
POSITIVE FEELINGS (“LIBIDINAL CATHEXIS”) TOWARD A DISAPPOINTING OBJECT –

IN THESE EXQUISITELY VULNERABLE PATIENTS
THE CAPACITY TO “HOLD” POSITIVE RELATIONAL EXPERIENCE
CAN BE ECLIPSED IN A HEARTBEAT
DURING MOMENTS OF AFFECTIVE OVERWHELM

FOR THESE EMOTIONALLY LABILE PATIENTS,

"AFFECTIVE INTENSITY" CAN ECLIPSE ACCESS TO THE "GOOD"

– NOT ONLY AS MEMORY, BUT ALSO AS POSSIBILITY –

"INTEGRATION STATEMENTS" GENTLY ACKNOWLEDGE THE PATIENT'S DIFFICULTY HOLDING THE "GOOD" IN MIND

– WHETHER RECALLING "WHAT WAS" OR IMAGINING "WHAT MIGHT BE" –

"HARD TO REMEMBER" / "HARD TO IMAGINE"

INSTEAD OF SAYING –

"BUT JUST LAST WEEK YOU WERE SAYING THAT YOU FELT GOOD ABOUT ME AND OUR WORK TOGETHER!"

IT IS MORE HELPFUL TO SAY –

"WHEN YOU'RE FEELING THIS ANGRY AT ME,
IT'S HARD TO REMEMBER THAT JUST LAST WEEK YOU WERE SAYING THAT YOU FELT GOOD ABOUT ME AND OUR WORK TOGETHER."

"WHEN YOU'RE FEELING THIS BAD,
IT'S HARD TO REMEMBER THAT YOU EVER FELT GOOD
AND HARD TO IMAGINE THAT YOU COULD EVER FEEL GOOD AGAIN."

"WHEN YOUR HEART IS BREAKING AS IT IS NOW,
YOU CAN'T IMAGINE THAT YOU COULD EVER DARE TO TRUST AGAIN."

"WHEN YOU'RE FEELING THIS DESPAIRING,
YOU CAN'T REMEMBER EVER HAVING HAD ANY HOPE WHATSOEVER."

INTEGRATION STATEMENTS DO NOT "CORRECT" THE BAD,
BUT INSTEAD MAKE SPACE FOR WHAT CANNOT YET BE "HELD"

IN OTHER WORDS

"INTEGRATION STATEMENTS" ADDRESS
BOTH THE "GOOD" AND THE "BAD" ASPECTS OF EXPERIENCE

THEY BEGIN BY RESONATING EMPATICALLY
WITH THE PATIENT'S EXPERIENCE OF THE "BAD"
– THE PAIN, THE RAGE, THE DESPAIR –
AND THEN GENTLY JUXTAPOSE THIS
WITH THE PATIENT'S DIFFICULTY
– IN THE FACE OF SUCH AFFECTIVE INTENSITY –
ACCESSING ANY SENSE OF THE "GOOD"

THAT DIFFICULTY MIGHT INVOLVE THE STRUGGLE
TO RECALL "PAST GOOD"
OR TO ENVISION THE POSSIBILITY OF "FUTURE GOOD"

THESE INTERVENTIONS DO NOT BOLDLY "COUNTER"
THE "BAD" WITH AN "IN – YOUR – FACE" REMINDER
OF EITHER PAST OR FUTURE "GOODNESS"

INSTEAD
THEY INDIRECTLY REFERENCE THE PATIENT'S
"DEFENSIVE EXCLUSION" OF THE "GOOD" FROM CONSCIOUSNESS –
A SELF – PROTECTIVE "FORGETTING" OF WHAT WAS,
OR "FORECLOSING" OF WHAT MIGHT BE,
THAT EMERGES IN MOMENTS OF EMOTIONAL OVERWHELM

. . . RESPECTFULLY ILLUMINATING THE PATIENT'S
"DIFFICULTY REMEMBERING" AND "DIFFICULTY ENVISIONING" THE "GOOD"

IN SUM

INTEGRATION STATEMENTS INVOLVE

– RESPECTFULLY, COMPASSIONATELY, AND NONJUDGMENTALLY –

"ALIGNING WITH"

THE PATIENT'S "DEFENSIVE NEED TO FORGET AND TO FORECLOSE"

IN MOMENTS OF EMOTIONAL OVERWHELM

– BY EMPATHICALLY RESONATING WITH

THE PATIENT'S DIFFICULTY REMEMBERING AND DIFFICULTY IMAGINING –

(THEREBY PROVIDING ANXIETY – ASSUAGING "SUPPORT" OF THE "DEFENSE")

AT THE SAME TIME

INTEGRATION STATEMENTS SUBTLY "INVITE AWARENESS" OF

– AND, AT TIMES, EVEN SUBLIMINALLY "EVOKE AWAKENING" OF –

THE PATIENT'S "ADAPTIVE CAPACITY TO REMEMBER AND TO ENVISION"

– BY GENTLY IMPLYING THE "GOOD" THAT HAD EXISTED IN THE PAST

AND THE POTENTIAL FOR "GOOD" TO EXIST AGAIN IN THE FUTURE –

(THEREBY, SOFTLY PROVIDING ANXIETY – PROVOKING "CHALLENGE" OF THE "DEFENSE")

AS SUCH

INTEGRATION STATEMENTS FOLLOW THE TRADITION

OF GENERATING "OPTIMALLY STRESSFUL"

– THAT IS, CREATING THE PRECISE BALANCE OF "SUPPORT" AND "CHALLENGE" –

GROWTH – INCENTIVIZING "MISMATCH EXPERIENCES"

– BETWEEN THE "DEFENSIVE NEED" TO KEEP THE "GOOD" AND THE "BAD" SPLIT

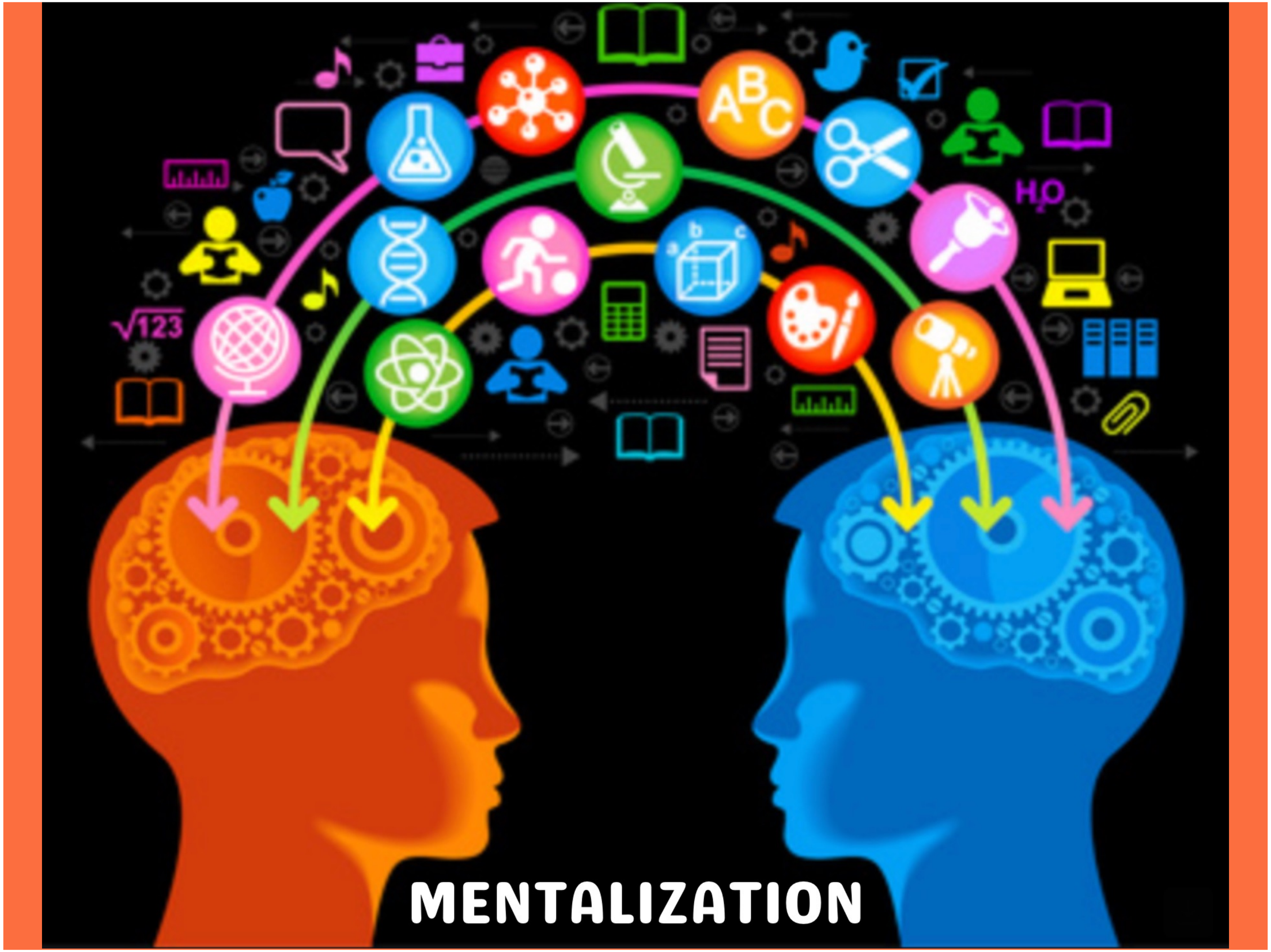
AND THE "ADAPTIVE CAPACITY" TO INTEGRATE THE "GOOD" AND THE "BAD" –

BY WAY OF SUMMARY

INTEGRATION STATEMENTS
GENTLY INTIMATE
THAT THERE MIGHT BE
AN "ALTERNATIVE" TO THE "DARKNESS"
– THAT THE PATIENT IS EXPERIENCING IN THE MOMENT –

INTEGRATION STATEMENTS
SUBTLY ENCOURAGE
THE PATIENT TO BE ATTUNED TO
THE CONTINUITY OF PAST, PRESENT, AND FUTURE
– ESPECIALLY RELEVANT FOR PATIENTS
WHO "LOSE TRACK" OF THIS ONGOING CONTINUITY
BECAUSE THEY HAVE DIFFICULTY "REMEMBERING" AND "IMAGINING" –

IN ESSENCE
INTEGRATION STATEMENTS
ARE STRATEGICALLY DESIGNED
TO SUPPORT THE DEVELOPMENT OF "AMBIVALENCE"
– THE CAPACITY TO HOLD IN MIND, SIMULTANEOUSLY,
"MIXED FEELINGS" ABOUT ONE'S OBJECTS
WITHOUT NEEDING TO "SPLIT" THE OBJECT INTO
AN "ALL – BAD" (NEED – FRUSTRATING) PART – OBJECT
AND AN "ALL – GOOD" (NEED – GRATIFYING) PART – OBJECT –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MENTALIZATION

TO NURTURE THE "CAPACITY TO MENTALIZE"
– MOST RELEVANT FOR THOSE STRUGGLING
WITH BORDERLINE VULNERABILITY AND FRAGILE CAPACITY,
YET ULTIMATELY RELEVANT ACROSS ALL DIAGNOSTIC CATEGORIES –
I HAVE CREATED A TWO – PART INTERVENTION
TO WHICH I REFER AS A "MENTALIZATION STATEMENT"

THESE STATEMENTS INVITE THE PATIENT
TO "THINK ABOUT THINKING," TO "WONDER ABOUT WONDERING,"
TO "HOLD MIND IN MIND"

MORE SPECIFICALLY
THEY GENTLY SUPPORT THE PATIENT'S EFFORTS
TO MAKE SENSE OF
– AND TO CULTIVATE "REFLECTIVE AWARENESS" ABOUT –
THE UNDERLYING MENTAL STATES
– OF BOTH SELF AND OTHERS –

. . . EVEN AS THEY RESPECTFULLY ACKNOWLEDGE
INEVITABLE MOMENTS OF CONFUSION, UNCERTAINTY, AND NOT – KNOWING
– WHETHER STEMMING FROM DEVELOPMENTAL LIMITATION (INABILITY)
OR DEFENSIVE STRATEGY (UNWILLINGNESS) –

AS WITH ALL THE OPTIMALLY STRESSFUL, GROWTH – INCENTIVIZING INTERVENTIONS
IN THE STARK METHOD of PSYCHODYNAMIC SYNERGY,
THESE STRATEGICALLY CONSTRUCTED STATEMENTS
FIRST "CHALLENGE" THE DEFENSE (WHETHER LIMITATION OR STRATEGY)
AND THEN "SUPPORT" IT
– FIRST INCREASING ANXIETY, THEN EASING IT –

“OPTIMALLY STRESSFUL,” GROWTH – INCENTIVIZING TWO – PART “MENTALIZATION STATEMENTS”

FIRST YOU GENTLY CHALLENGE BY “LEADING THE WITNESS” JUST ENOUGH TO STRETCH THEM TOWARD MENTALIZATION – ABOUT EITHER THEIR OWN OR THE OTHER’S MENTAL STATE – BUT THEN YOU CUSHION IT WITH EMPATHIC SUPPORT

YOU ARE INVITING THEM TO LEAN INTO CURIOSITY ABOUT EITHER THEIR OWN OR THE OTHER’S INNER EXPERIENCE AND ITS IMPACT ON BEHAVIOR, BUT THEN YOU SOFTEN IT BY RESONATING EMPATHICALLY WITH THEIR CONFUSION AND LACK OF CERTAINTY

“SELF – INTERNAL” FOCUS
“YOU KNOW IT’S IMPORTANT THAT YOU (EVENTUALLY) BE ABLE TO MAKE SENSE OF THE < X > THAT YOU’RE FEELING, THINKING, OR DOING RIGHT NOW (AND ITS POTENTIAL IMPACT ON OTHERS) BUT IT’S NOT ALWAYS EASY TO KNOW EXACTLY WHAT THAT MIGHT BE.”

“OTHER – EXTERNAL” FOCUS
“YOU KNOW IT’S IMPORTANT THAT YOU (EVENTUALLY) BE ABLE TO MAKE SENSE OF THE < X > THAT THE OTHER PERSON MIGHT BE FEELING, THINKING, OR DOING RIGHT NOW (AND ITS POTENTIAL IMPACT ON YOU) BUT IT’S NOT ALWAYS EASY TO KNOW EXACTLY WHAT THAT MIGHT BE.”

EXAMPLES OF "SELF – INTERNAL" MENTALIZATION STATEMENTS

– HIGHLIGHTING THE INTERPLAY OF EXPERIENCE, COGNITION, AND BEHAVIOR –

**"YOU KNOW IT'S IMPORTANT THAT YOU EVENTUALLY YOU BE ABLE
TO UNDERSTAND WHY YOU ARE ALWAYS SO ANGRY
AND HOW THAT CAN IMPACT PEOPLE,
BUT AT THIS MOMENT IT JUST SEEMS TOO OVERWHELMING."**

**"YOU KNOW IT'S IMPORTANT THAT YOU BE ABLE
TO MAKE SENSE OF THE AGITATION
THAT YOU'RE FEELING RIGHT NOW,
BUT IT ISN'T ALWAYS EASY TO KNOW."**

**"YOU KNOW IT'S IMPORTANT THAT YOU EVENTUALLY BE ABLE
TO MAKE SENSE OF THE PANIC THAT'S RISING INSIDE YOU,
BUT YOU CAN'T, FOR THE LIFE OF YOU,
FIGURE OUT WHAT IT'S ALL ABOUT."**

**"YOU KNOW IT'S IMPORTANT TO FIGURE OUT
WHY YOU ARE WANTING TO LASH OUT AT THE WORLD RIGHT NOW,
BUT, DESPITE YOUR BEST EFFORTS,
YOU CAN'T REALLY MAKE SENSE OF IT."**

**"YOU KNOW IT'S IMPORTANT THAT EVENTUALLY YOU BE ABLE
TO PUT INTO WORDS
HOW DESPERATE YOU'RE FEELING RIGHT NOW
BUT IT ALL FEELS JUST SO OVERWHELMING."**

EXAMPLES OF "OTHER – EXTERNAL" MENTALIZATION STATEMENTS

– HIGHLIGHTING THE INTERPLAY OF EXPERIENCE, COGNITION, AND BEHAVIOR –

"YOU KNOW IT'S IMPORTANT THAT YOU BE ABLE
TO FIGURE OUT WHY PEOPLE SOMETIMES GET SO MAD AT YOU
AND WHAT YOU MIGHT BE DOING TO MAKE THAT HAPPEN,
BUT IT ISN'T ALWAYS EASY TO FIGURE OUT WHAT THAT MIGHT BE."

"YOU KNOW IT'S IMPORTANT THAT YOU BE ABLE
TO MAKE SENSE OF THE PANIC
THAT SEEMS TO BE TAKING HOLD OF THE OTHER PERSON,
BUT YOU CAN'T, FOR THE LIFE OF YOU,
FIGURE OUT WHAT IT'S ALL ABOUT."

"YOU KNOW IT'S IMPORTANT TO FIGURE OUT
WHY THE OTHER PERSON MIGHT WANT
TO HURT YOU RIGHT NOW,
BUT YOU CAN'T REALLY MAKE SENSE OF IT
OR OF WHAT YOU MIGHT HAVE DONE TO PROVOKE IT."

"YOU KNOW IT'S IMPORTANT THAT YOU BE ABLE
TO PUT INTO WORDS HOW DESPERATE
THE OTHER PERSON MUST BE FEELING RIGHT NOW,
BUT IT ALL FEELS JUST SO OVERWHELMING."

"YOU KNOW IT'S IMPORTANT THAT YOU BE ABLE
TO UNDERSTAND WHY THE OTHER PERSON
IS ALWAYS SO ANGRY WITH YOU,
BUT YOU JUST CAN'T FIGURE IT OUT."

OPTIMALLY STRESSFUL, GROWTH – INCENTIVIZING INTERVENTIONS ADVANCE THE THERAPEUTIC PROCESS IN MULTIPLE WAYS

REAL – TIME MODELING OF MENTALIZATION

THE THERAPIST IS DEMONSTRATING WHAT IT LOOKS LIKE
TO HOLD AN AFFECT IN MIND AND REFLECT UPON IT –
NAMING A FEELING (SELF – INTERNAL OR OTHER – EXTERNAL)
WHILE SIMULTANEOUSLY ACKNOWLEDGING
THE DIFFICULTY MAKING SENSE OF IT

STRETCHING WITHOUT OVERWHELMING

THE THERAPIST IS GENTLY CHALLENGING THE PATIENT
TO NOTICE, NAME, AND WONDER ABOUT MENTAL STATES,
BUT IS THEN SOFTENING THAT CHALLENGE
WITH EMPATHIC VALIDATION OF CONFUSION.
THIS CREATES "OPTIMAL STRESS" –
ENOUGH TO FOSTER GROWTH, NOT SO MUCH AS TO SHUT IT DOWN

INTEGRATING AFFECT WITH MEANING

THE THERAPIST IS BRIDGING THE GAP
BETWEEN RAW EMOTIONAL EXPERIENCE
– "THE PANIC RISING INSIDE YOU" –
AND REFLECTIVE UNDERSTANDING
– "WHAT IT'S ALL ABOUT" –
THEREBY ENCOURAGING THE PATIENT TO CONNECT FEELINGS
WITH CAUSES, INTENTIONS, AND CONTEXT

OPTIMALLY STRESSFUL, GROWTH – INCENTIVIZING INTERVENTIONS ADVANCE THE THERAPEUTIC PROCESS IN SEVERAL WAYS

SHIFTING FROM IMPLICIT TO EXPLICIT

THE THERAPIST IS HELPING THE PATIENT
MOVE FROM SENSED BUT UNFORMULATED EXPERIENCE
TOWARD REPRESENTED, THINKABLE EXPERIENCE
– THE ESSENCE OF BUILDING MENTALIZING CAPACITY –

TAKING A RELATIONAL PERSPECTIVE

THE OTHER – EXTERNAL STATEMENTS ARE CULTIVATING
THE PATIENT'S ABILITY TO IMAGINE ANOTHER MIND,
A CRUCIAL STEP IN DEVELOPING
MORE RESILIENT, FLEXIBLE, AND ATTUNED RELATIONSHIPS

IN SHORT

BY ALTERNATING GENTLE CHALLENGE
– NAMING AND STRETCHING TOWARD REFLECTION –
WITH EMPATHIC CUSHIONING
– VALIDATING CONFUSION AND DIFFICULTY KNOWING WITH CERTAINTY –
THE THERAPIST'S MENTALIZATION STATEMENTS
ARE SUPPORTING
THE PATIENT'S CAPACITY TO MENTALIZE
– ABOUT BOTH SELF AND OTHERS –


GRATIFICATION OF THE NEED
FOR EXTERNAL CONTAINMENT
CONTAINED
A NEW KIND OF EXPERIENCE

TO FACILITATE CRITICALLY IMPORTANT EXTERNAL CONTAINMENT
THE THERAPIST DRAWS UPON THREE
"OPTIMALLY STRESSFUL," GROWTH – INCENTIVIZING INTERVENTIONS

CONTAINING STATEMENTS

JUXTAPOSE "EMPATHIC RESONANCE" WITH "INSISTENCE UPON ACCOUNTABILITY"

"YOU'RE FEELING TERRIBLE RIGHT NOW, CURSING THE DAY YOU EVER MET ME,
AND CONVINCED THAT YOU CAN NEVER TRUST ME AGAIN. BUT WE BOTH KNOW
THAT SURVIVING THESE CRISES IS PART OF OUR WORK. WE'VE DONE IT BEFORE,
AND WE'LL DO IT AGAIN. NOBODY SAID IT WOULD BE EASY."

INTEGRATION STATEMENTS

JUXTAPOSE "EMPATHIC RESONANCE" WITH "INVITATION TO AWARENESS"

"WHEN YOU'RE FEELING THIS ENRAGED,
IT'S HARD TO REMEMBER THAT YOU HAD EVER FELT GOOD ABOUT ME OR OUR WORK TOGETHER
AND EQUALLY HARD TO IMAGINE THAT YOU COULD EVER FEEL GOOD ABOUT US AGAIN."

MENTALIZATION STATEMENTS

JUXTAPOSE "GENTLE CHALLENGE" WITH "EMPATHIC CUSHIONING"

"YOU KNOW IT'S IMPORTANT THAT YOU FIGURE OUT
WHAT'S GOING ON INSIDE YOU WHEN YOU'RE THIS ENRAGED,
BUT IT ALL FEELS SO OVERWHELMING RIGHT NOW THAT IT'S HARD EVEN
TO THINK ABOUT WHAT MIGHT HAVE CAUSED YOUR ANGER."

AS WE KNOW

IT IS THE THERAPIST'S PROVISION OF EXTERNAL CONTAINMENT
THAT MAKES IT POSSIBLE FOR THE RELATIONSHIP TO CONTINUE

– DESPITE THE FREQUENT STORMS AND CRISES –

WHENEVER THE PATIENT IS DISAPPOINTED, FRUSTRATED, OR THWARTED IN HER DESIRE,

THE THERAPIST "MEETS" THE PATIENT'S AGGRESSION
AND SURVIVES THE PATIENT'S REPEATED ATTEMPTS
TO DESTROY HER AND THEIR RELATIONSHIP

AGAIN AND AGAIN

THE THERAPIST PROVES HER INDESTRUCTIBILITY

IN SURVIVING THE PATIENT'S ATTEMPTS TO DESTROY HER,

THE THERAPIST GIVES THE PATIENT SOMETHING
SHE HAS NEVER BEFORE EXPERIENCED

– NAMELY, THE "EXPERIENCE OF STEADFAST CONTAINMENT" –

INDEED, WHEN THE THERAPIST CAN MEET THE PATIENT'S URGENT NEED
TO HAVE HER IMPULSIVE, RAGEFUL, AND DESTRUCTIVE BEHAVIORS LIMITED AND CONTAINED,

THE PATIENT WILL GAIN A NEW KIND OF EXPERIENCE –

. . . THE POWERFULLY TRANSFORMATIVE EXPERIENCE
OF HAVING INTENSE AFFECT

– INCLUDING MURDEROUS RAGE, DEBILITATING ANXIETY, AND SUICIDAL DESPAIR –

WITHOUT DEVASTATING CONSEQUENCE

IN THE MOMENTS OF DEVASTATING DISILLUSIONMENT

THE PATIENT WITH BORDERLINE DEFENSES

– LACKING THE INTERNAL STRUCTURE TO WEATHER THE "CRISIS" –

LOSES HOLD OF ALL THAT HAD ONCE BEEN "GOOD"

IN THE GRIP OF HER UNMODULATED, DYSREGULATED RAGE

SHE IS DRAWN TOWARD RETALIATION

– EVEN IF IT MEANS DESTROYING THE VERY RELATIONSHP SHE HAS COME TO TREASURE –

THE THERAPIST'S WILLINGNESS, AND ABILITY,
TO "MEET" THE PATIENT'S AGGRESSION,
HER UNWAVERING STEADFASTNESS IN THE FACE OF IT,
AND HER CONSISTENT PROVISION OF EXTERNAL CONTAINMENT

– OF THE PATIENT'S DESTRUCTIVE ACTING OUT –

WILL ENABLE THE RELATIONSHIP
NOT ONLY TO SURVIVE BUT TO ENDURE AND EVOLVE

. . . SURVIVAL, HERE, MEANING THE EVER – EVOLVING CAPACITY
OF THE RELATIONSHIP TO WITHSTAND
THE FREQUENT STORMS AND INEVITABLE CRISES

– THAT WOULD ONCE HAVE TORN THE RELATIONAL FABRIC APART –

BUT THE THERAPIST REFUSES TO ALLOW THE PATIENT
TO DESTROY THE RELATIONSHIP

– JUST AS SHE REFUSES TO ALLOW HERSELF TO BE ABUSED –

INDEED

IF THE PATIENT IS GENTLY, YET FIRMLY,
"ANCHORED" IN THE RELATIONSHIP
BY A THERAPIST WHO STEADFASTLY REFUSES TO COLLUDE
WITH THE PATIENT'S IMPULSE TO "DESTROY"

AND, INSTEAD, OFFERS A "PROTECTED SPACE"
WITHIN WHICH THE PATIENT CAN GIVE VOICE
TO HER ANGUISH, PANIC, DESPERATION, AND OUTRAGE
– HER WISH TO ESCAPE, TO LASH OUT, TO RETALIATE, EVEN TO DESTROY –

THEN, IN TIME, SHE MIGHT BE ABLE TO RECLAIM
THE GOOD FEELINGS SHE ONCE KNEW

. . . NOT BECAUSE THE RAGE HAS BEEN SILENCED,
BUT BECAUSE IT HAS BEEN WELCOMED INTO LANGUAGE
– "MENTALIZATION" –
MET WITH EMPATHY AND UNDERSTANDING,
HELD WITHIN THE THERAPIST'S EMOTIONAL ROBUSTNESS,
AND ALLOWED TO RUN ITS TRUE COURSE
– WITHOUT JUDGMENT, WITHOUT RETALIATION, WITHOUT COLLAPSE –

HELD, NAMED, AND UNDERSTOOD – NOT ENACTED

. . . PERHAPS MONTHS, PERHAPS WEEKS, SOMETIMES EVEN DAYS
BUT WITH EACH EXCHANGE THE PATIENT MOVES CLOSER
TO RECLAIMING WHAT WAS LOST
– STEP BY STEP, WITHIN THE CALM, STEADY HOLD OF THE RELATIONSHIP –

IN TIME

THE PATIENT BEGINS TO RECOVER HER GOOD FEELINGS

– THE DISAPPOINTMENT IS SURVIVED,
AND THE RELATIONSHIP, AT LEAST FOR THE MOMENT, ENDURES –

THE THERAPIST CAN THEN INTRODUCE SOMETHING
TO WHICH I REFER AS AN "INVERTED INTEGRATION STATEMENT"

THESE INTERVENTIONS ARE USED
NOT WHEN THE PATIENT IS FEELING "BAD,"
BUT IN THOSE MOMENTS WHEN HOPE HAS RETURNED
AND THE PATIENT IS TRULY FEELING "GOOD"

AN "INVERTED INTEGRATION STATEMENT"
UNDERLINES THE FACT THAT

– WHEN THE PATIENT IS INDEED FEELING "GOOD" –

IT CAN BECOME DIFFICULT TO RECALL
THE "BAD" THAT HAD COME BEFORE

"WHEN YOU'RE FEELING THIS GOOD,
IT'S HARD TO REMEMBER THAT YOU HAD EVER HAD DOUBTS
ABOUT ME AND OUR WORK TOGETHER."

"WHEN YOU'RE FEELING HOPEFUL, AS YOU ARE NOW,
YOU FIND YOURSELF WANTING TO FORGET ABOUT THE TIMES
WHEN YOU WERE FILLED WITH DESPAIR, RAGE, AND DEEP UNCERTAINTY."

IN ESSENCE

THE THERAPIST

– MAINTAINING HER PERSPECTIVE THROUGHOUT –

(BOTH THE LOWS AND THE HIGHS OF THE THERAPEUTIC ENGAGEMENT)

IS SIMPLY REMINDING THE PATIENT THAT "THIS TOO SHALL PASS"

. . . NOT BECAUSE THE THERAPIST IS A "DEBBIE DOWNER,"
BUT BECAUSE SHE SEEKS TO HIGHLIGHT THE CONTINUITY
OF THE PATIENT'S INTERNAL EXPERIENCE

– THE CONTINUITY OF HER BEING –

– THE THREAD CONNECTING PAST, PRESENT, AND FUTURE –

IN THIS WAY

SHE IS ATTEMPTING TO INTEGRATE
BOTH THE "GOOD" AND THE "BAD"
IN THE PATIENT'S EXPERIENCE OF SELF AND OTHERS

– MODELING THAT VERY INTEGRATION THROUGH HER INTERVENTIONS –

IN ADDITION TO CONTAINING, INTEGRATION, AND MENTALIZATION STATEMENTS,

THE THERAPIST MAKES LIBERAL USE OF
BOTH THE "INTEGRATION STATEMENT"

– RECOGNIZING HOW HARD IT IS TO REMEMBER THE "GOOD"
IN THE FACE OF THE PRESENT "BAD" –

AND THE "INVERTED INTEGRATION STATEMENT"

– REMINDING THE PATIENT OF THE "BAD"
THAT HAD PRECEDED THE CURRENT EXPERIENCE OF "GOOD" –

THE ALTERNATION
BETWEEN "BAD" FOLLOWED BY "GOOD"
AND "GOOD" FOLLOWED BY "BAD"
– FRUSTRATION GIVING WAY TO GRATIFICATION,
GRATIFICATION GIVING WAY TO FRUSTRATION –
BECOMES A RECURSIVE, INTEGRATIVE RHYTHM
WITHIN THE PATIENT'S EVOLVING EXPERIENCE
OF THE THERAPIST

THIS ONGOING OSCILLATION
– BETWEEN RUPTURE AND REPAIR,
BETWEEN SATISFACTION AND DISAPPOINTMENT –
ESTABLISHES A DEEP EMOTIONAL CADENCE,
AN EVER – EXPANDING FLOW WITHIN THE RELATIONAL FIELD

PATIENT AND THERAPIST CONTINUALLY "MEET"
AT THEIR "INTIMATE EDGE"
– NAVIGATING THE DELICATE INTERPLAY OF VULNERABILITY AND STRENGTH –

IN SO DOING,
THEY GRADUALLY CULTIVATE
A FOUNDATION OF
MUTUAL TRUST AND DEEPENING UNDERSTANDING

THE INTEGRATIVE PROCESS

– OF CONTAINMENT, INTEGRATION, AND MENTALIZATION,
WORKING IN DYNAMIC SYNERGY –

UNFOLDS AS FOLLOWS –

THE PATIENT EXPERIENCES DISAPPOINTMENT,
STRUGGLES TO TOLERATE IT,
AND FEELS SORELY TEMPTED TO ACT OUT

– IN IMPULSIVE, RAGEFUL, INDULGENT, OR DESTRUCTIVE WAYS –

BUT THE "STALWART" THERAPIST

– RELIABLE AND UNWAVERING –

PROVIDES "EXTERNAL CONTAINMENT"

– ANCHORED BY "CONTAINING STATEMENTS" –

FOSTERS "ADAPTIVE INTEGRATION" OF "GOOD" AND "BAD"

– BY MEANS OF "INTEGRATION STATEMENTS"
AND "INVERTED INTEGRATION STATEMENTS" –

AND CULTIVATES "REFLECTIVE AWARENESS"

– FACILITATED BY "MENTALIZATION STATEMENTS" –

ALL OF WHICH DETER
THE PATIENT'S PRONENESS TO
"DEFENSIVE SPLITTING" AND "UNREFLECTIVE ACTING OUT"

– IN THE FACE OF "EMOTIONAL OVERWHELM" –

THE THERAPIST REPEATEDLY DEMONSTRATES
HER RELIABILITY, CONSISTENCY,
AND FAITH IN THE DURABILITY OF THE PATIENT
– AND OF THEIR CONNECTION –

WHICH ALLOWS THE RELATIONSHIP TO ENDURE,
THE STORM TO BE WEATHERED,
AND THE PATIENT'S "GOOD" FEELINGS TO BE RESTORED

THE CYCLE REPEATS ITSELF, AGAIN AND AGAIN

THE PATIENT'S INNER EXPERIENCE BECOMES ONE OF –

STORM, STILLNESS
CRISIS, RESOLUTION
RUPTURE, REPAIR
LOSS, RECOVERY
DISAPPOINTMENT, RELIEF
BAD, GOOD

THIS OSCILLATION PROGRESSES
AT AN EVER – ACCELERATING PACE
– WITH THE "RECOVERY TIME" AFTER EACH DESTABILIZING DISILLUSIONMENT
GROWING SHORTER AND SHORTER –

IN ESSENCE

THE PATIENT DISCOVERS

THAT SHE CAN

– TIME AND AGAIN –

“SURVIVE” THE VACILLATION

BETWEEN THE “BAD” AND THE “GOOD”

– BETWEEN DEVASTATING LOWS AND ENLIVENING HIGHS –

AND, IN TURN,

THE THERAPEUTIC RELATIONSHIP ITSELF

GROWS INCREASINGLY RESILIENT

– STRENTHENING PRECISELY AT THE BROKEN PLACES –

THE PATIENT IS BEGINNING TO EXPERIENCE

– IN A DEEPLY EMBODIED WAY –

THE “COALESCING IMPACT”

OF THIS RHYTHMIC, CYCLICAL DANCE

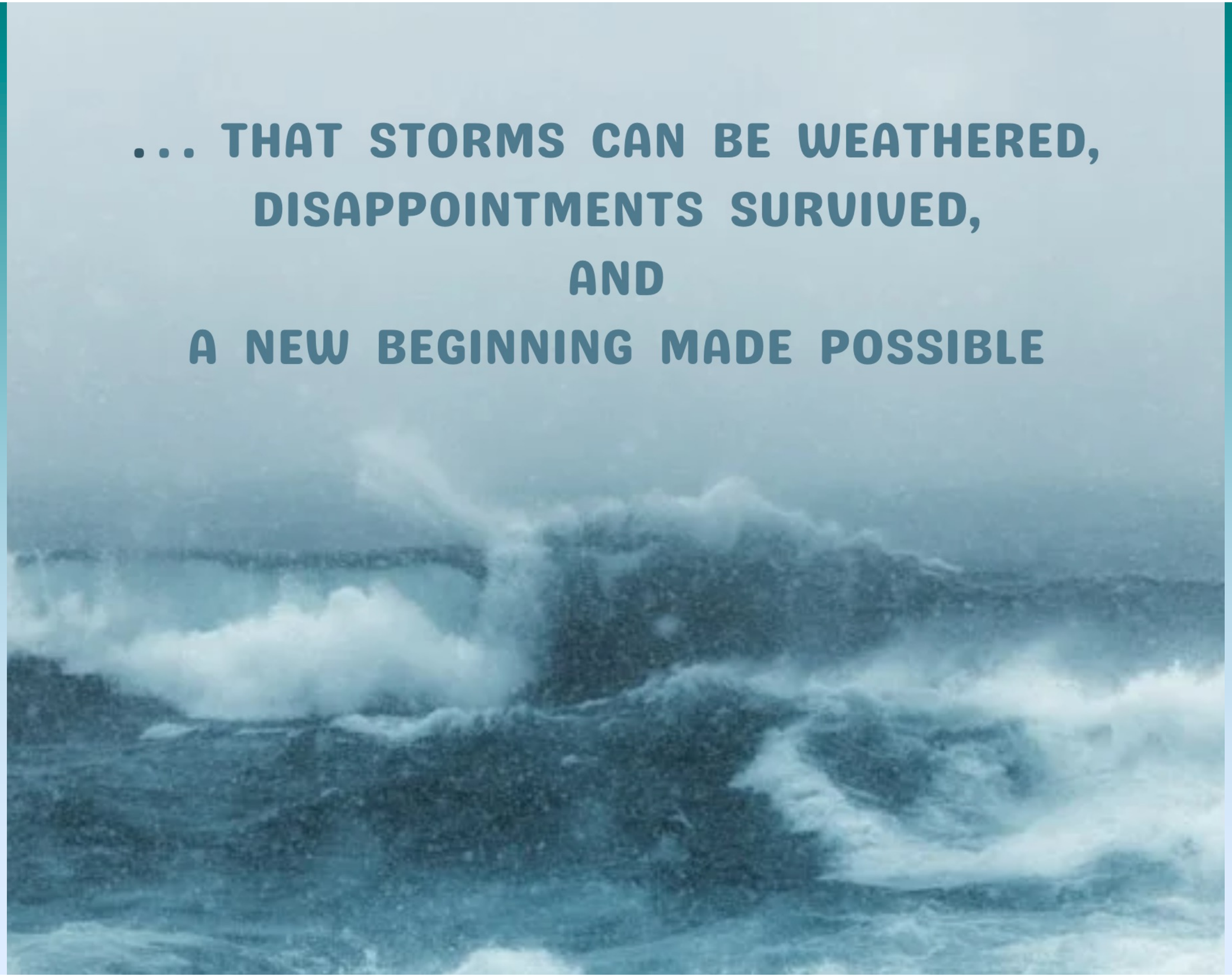
OF “BEING IN RELATIONSHIP” WITH SOMEONE

– WHO REMAINS STEADY, RELIABLE,
DURABLE, COMMITTED, AND EMOTIONALLY INVESTED –
– WHO STAYS EMPATHICALLY ATTUNED, EVEN AMID REPEATED RUPTURES –
(REFUSING TO WITHDARW, RETALIATE, OR GIVE UP)

AND SO, PERHAPS FOR THE FIRST TIME,

THE PATIENT FINDS HERSELF BEGINNING TO “BELIEVE” . . .

... THAT STORMS CAN BE WEATHERED,
DISAPPOINTMENTS SURVIVED,
AND
A NEW BEGINNING MADE POSSIBLE



THE PATIENT'S REPEATED,
"EMBODIED" EXPERIENCE OF –

RUPTURE AND REPAIR
LOSS AND RECOVERY
BAD AND GOOD
– IN EVER – MORE RAPID SUCCESSION –

GRADUALLY CULTIVATES THE INTERNAL CAPACITY
TO "HOLD IN MIND"
THE FULL "LIVED EXPERIENCE"
OF BOTH "BAD" AND "GOOD" SIMULTANEOUSLY
– NOT ONLY THE "LOVED" AND "HATED" ASPECTS OF THE OBJECT,
BUT ALSO THE "LOVING" AND "HATEFUL" DIMENSIONS OF THE SELF –

THIS DEEPLY LIVED
"RELATIONAL RHYTHM" FOSTERS
AN INCREASINGLY "CONSOLIDATED"
SENSE OF SELF AND OTHERS
– EACH CAPABLE OF HARBORING
BOTH THE "GOOD" AND THE "BAD" –

AT THIS POINT,

THE PATIENT

– WHO ONCE STRUGGLED WITH "DEFENSIVE SPLITTING"
AND THE "PRE – AMBIVALENT" USE OF "PART – OBJECTS" –

IS RELATING TO OTHERS

NOT AS "ALL – GOOD" OR "ALL – BAD" PART – OBJECTS

– THAT EITHER GRATIFY OR FRUSTRATE –

BUT AS "GOOD – AND – BAD" WHOLE OBJECTS

– CAPABLE OF BOTH GRATIFYING AND FRUSTRATING –

THE PATIENT

– WHO WAS ONCE UNABLE TO "SELF – CONTAIN"
"UNINTEGRATED PSYCHIC TENSION" AND "OVERWHELMING AFFECTIVE STORMS"
AND THEREFORE PRE – REFLECTIVELY ENACTED INTERNAL DRAMAS
ON THE STAGE OF HER LIFE
IN IMPULSIVE, RAGEFUL, AND OFTEN DESTRUCTIVE WAYS –

HAS NOW DEVELOPED THE CAPACITY

TO HOLD "PAINFUL OSCILLATIONS WITHIN THE SELF"

AND TO WITHSTAND "EMOTIONAL TURBULENCE"

– WITHOUT DISCHARGING "INTERNAL TURMOIL" INTO THE EXTERNAL WORLD –

SHE NO LONGER NEEDS TO "PLAY OUT"

DYSREGULATED "INTERNAL STATES" IN HER RELATIONSHIPS,

BUT, INSTEAD, CAN HOLD, REFLECT,

AND ULTIMATELY MENTALIZE THEM

– WITHIN A MORE COHESIVE, INTEGRATED, AND ENDURING SENSE OF SELF –

FINAL REFLECTIONS

IN SUM

– WITH RESPECT TO THE DEVELOPMENT OF "EVOCATIVE MEMORY CAPACITY"
IN PATIENTS WHO RELY ON BORDERLINE DEFENSES IN THE FACE OF OVERWHELM –
IT WILL NOT BE THE PATIENT'S "EXPERIENCE"
OF "GRIEVING DISILLUSIONMENT"
WITH AN "IDEALIZED SELFOBJECT" THERAPIST

BUT RATHER THE "EXPERIENCE"
OF "BEING HELD IN RELATIONSHIP"
BY A "CONTAINING SELFOBJECT" THERAPIST
WHO PROVES HERSELF "INDESTRUCTIBLE"
– REFUSING TO BE DAUNTED BY THE PATIENT'S
DISILLUSIONMENT, OUTRAGE, OR
THREATS TO ACT OUT IMPULSIVELY AND RAGEFULLY –

IN OTHER WORDS
IT WILL BE THE THERAPIST'S CONSISTENT "GRATIFICATION"
OF THE PATIENT'S "NEED FOR CONTAINMENT"
THAT WILL PROVIDE
BOTH THE IMPETUS AND THE OPPORTUNITY
FOR DEVELOPMENT
OF "EVOCATIVE MEMORY CAPACITY"
AND, THEREFORE, THE PATIENT'S "CAPACITY TO GRIEVE"

IN ESSENCE

TRANSFORMATION OF THE RELENTLESS SEARCH
FOR EXTERNAL PERFECTION
INTO SELF – SUSTAINING RESILIENCE

– AND THE INTERNAL ACCEPTANCE OF "GOOD – ENOUGH" –

WILL BE THE FELICITOUS OUTCOME

NOT "GRIEVING OPTIMAL FAILURE"
BUT "ENCOUNTERING OPTIMAL CONTAINMENT"

ULTIMATELY

RESILIENT "SELF – SUPPORT"

– THE ADAPTIVE CAPACITY TO BE A "GOOD – ENOUGH" CAREGIVER UNTO ONESELF –

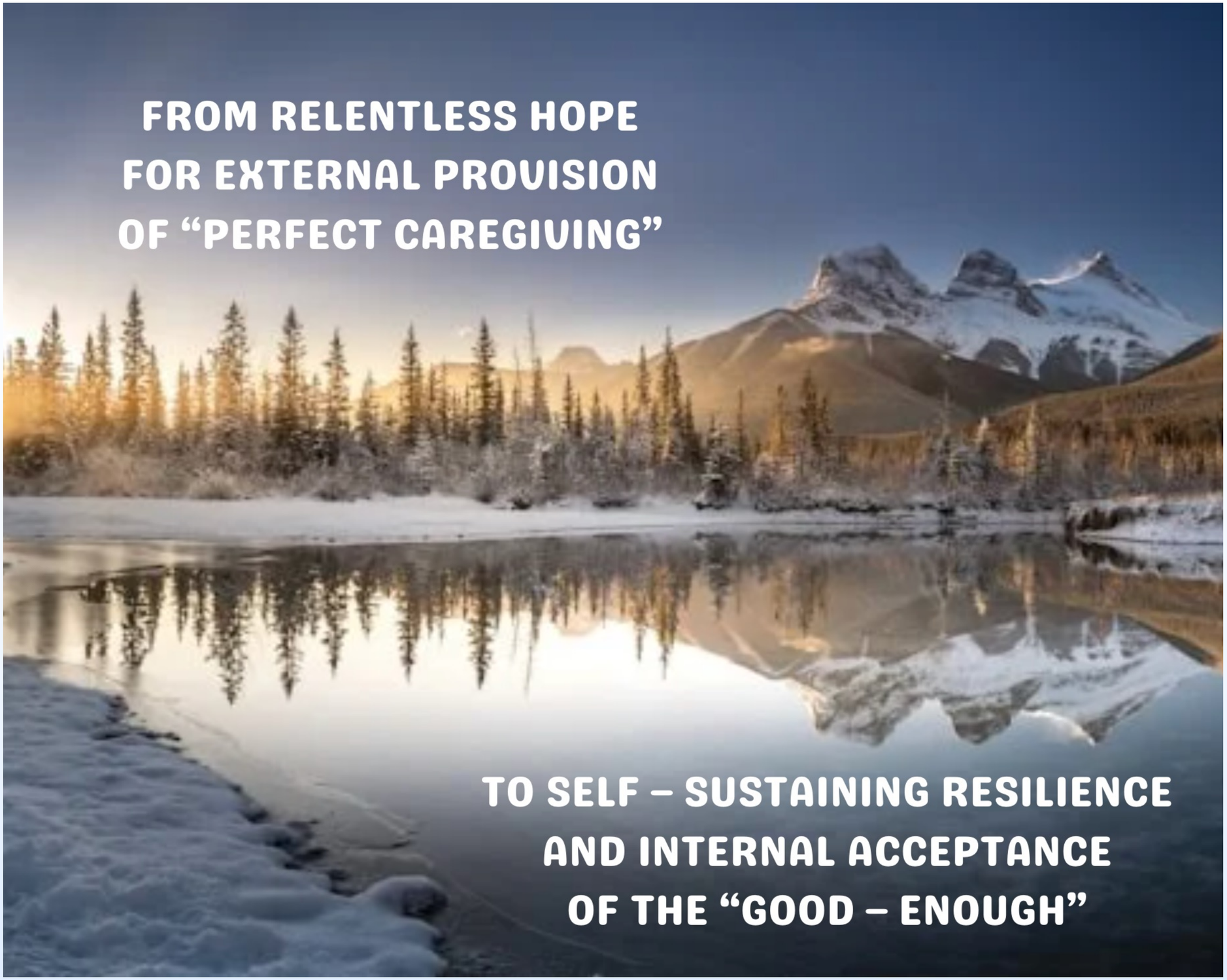
WILL BECOME THE ANTIDOTE
TO THE RELENTLESS PURSUIT OF
"IDEALIZED EXTERNAL CAREGIVING"
AND "PERFECT ATTUNEMENT"

THE HARD – EARNED ABILITY TO BE DEEPLY SATISFIED
WITH BEING THE SOURCE OF ONE'S OWN SUSTENANCE

– AND WITH THE "GOOD – ENOUGH ATTUNEMENT" REAL LIFE PROVIDES –

IS THE HALLMARK OF SUCCESSFUL TRANSFORMATION –
FROM "RELENTLESS HOPE" INTO "REALITY – BASED HOPE"

– THE SOBER, MATURE ACCEPTANCE THAT STORMS CAN BE WEATHERED,
DISAPPOINTMENTS SURVIVED, AND A NEW BEGINNING MADE POSSIBLE –


FROM RELENTLESS HOPE
FOR EXTERNAL PROVISION
OF “PERFECT CAREGIVING”
TO SELF – SUSTAINING RESILIENCE
AND INTERNAL ACCEPTANCE
OF THE “GOOD – ENOUGH”

I AM REMINDED OF A BELOVED PATIENT OF MINE
WHO ENTERED TREATMENT WITH A DIAGNOSIS OF BPD,
A TRAIL OF FAILED THERAPIES BEHIND HER,
AND A SERIES OF EXHAUSTED, DEFEATED,
AND ENRAGED THERAPISTS IN HER WAKE

BUT AFTER EIGHT YEARS OF INTENSIVE PSYCHODYNAMIC WORK WITH ME
– THROUGH MANY BATTLES, REPEATED EFFORTS TO TAKE ME DOWN,
AND BEGRUDGED GRIEVING ALONG THE WAY,
AS SHE CAME TO TERMS WITH PREVIOUSLY UNBEARABLE TRUTHS –
SHE WAS NO LONGER "A BORDERLINE"

HER PARTING WORDS, AS WE TERMINATED, STILL RESONATE –
"YOU'RE THE KIND OF PERSON
WHO WOULD KICK THE CRUTCHES OUT
FROM UNDERNEATH A CRIPPLE.
THANK YOU!"

I STILL CHUCKLE AS I REMEMBER . . .

THANK YOU!

IF YOU WOULD LIKE TO BE
ON MY MAILING LIST
OR WOULD LIKE TO JOIN
MY ENTIRELY F.R.E.E. 90 - MINUTE WEEKLY
Spot Supervision ZOOM Sessions
- BOTH "LIVE" (every Thursday - 12 to 1:45 pm (ET))
AND "RECORDED" FOR LATER VIEWING
ON MY PRIVATE YouTube CHANNEL -

PLEASE EMAIL ME AT
MarthaStarkMD @ SynergyMed.solutions

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