MODEL 3

THE THERAPIST'S FAILURES AS
INEVITABLE,
NECESSARY,
AND EVEN DESIRABLE

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CONTEMPORARY RELATIONAL THEORY
POSTULATES THAT IT IS
NOT ONLY INEVITABLE
BUT ALSO NECESSARY
– AND THEREFORE DESIRABLE –
FOR THE THERAPIST
ULTIMATELY TO FAIL THE PATIENT
AND IN THE VERY WAYS THAT
THE PATIENT MOST NEEDS
TO BE FAILED
IF SHE IS EVER TO HAVE
THE OPPORTUNITY TO MODIFY
HER TOXIC INTROJECTS
AND THEIR NEGATIVE,
SELF – SABOTAGING VOICES

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IF THE THERAPIST NEVER ALLOWS HERSELF
TO BE DRAWN IN TO PARTICIPATING WITH THE
PATIENT IN HER DRAMATIC RE – ENACTMENTS

WE SPEAK OF A FAILURE OF
ENGAGEMENT AND LOST OPPORTUNITY

IF, HOWEVER, THE THERAPIST ALLOWS HERSELF
TO BE DRAWN IN TO THE
PATIENT'S INTERNAL DRAMAS BUT THEN
GETS OVERWHELMED, LOSES HER WAY,
AND CANNOT FIND HER WAY OUT

WE SPEAK OF A FAILURE OF
CONTAINMENT AND THE POTENTIAL
FOR RE – TRAUMATIZATION

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THE MODEL 3 "RELATIONAL" THERAPIST MUST THEREFORE BE ABLE TO PROVIDE CONTAINMENT

SHE MUST BE ABLE NOT ONLY TO TOLERATE BEING MADE INTO THE PATIENT'S OLD BAD OBJECT

BUT ALSO

ONCE THE THERAPIST HAS INDEED ALLOWED HERSELF TO BE DRAWN IN TO PARTICIPATING IN WHAT HAS BECOME A MUTUAL ENACTMENT

TO EXTRICATE HERSELF BY STEPPING BACK

WHICH WILL ENABLE HER TO RECOVER HER OBJECTIVITY AND THEREBY HER THERAPEUTIC EFFECTIVENESS

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AND IN ORDER TO PROVIDE EFFECTIVE CONTAINMENT

THE THERAPIST MUST HAVE THE CAPACITY TO RELENT

IN OTHER WORDS

THE THERAPIST MUST HAVE BOTH THE WISDOM TO RECOGNIZE AND THE INTEGRITY TO ACKNOWLEDGE

CERTAINLY TO HERSELF AND PERHAPS TO THE PATIENT AS WELL

HER OWN PARTICIPATION IN THE DRAMA THAT IS BEING PLAYED OUT BETWEEN THEM ON THE STAGE OF THE TREATMENT

IN ESSENCE

THE THERAPIST MUST HAVE THE CAPACITY BOTH TO RELENT AND TO HOLD HERSELF ACCOUNTABLE FOR HER ENACTMENTS

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PLEASE NOTE

ALTHOUGH THE EMPHASIS TO THIS POINT HAS BEEN ON "PAIRED" PATHOGENIC INTROJECTS

– THE RESULT OF "DYSFUNCTIONAL EARLY – ON RELATIONAL DYNAMICS" –

AND ON "NEGOTIATING AT THE INTIMATE EDGE" TO DETOXIFY THEIR PATHOGENICITY

THE PATIENT IDENTIFYING WITH EITHER THE MORE "PASSIVE" POLE OR THE MORE "ACTIVE" POLE OF THE "INTROJECTIVE CONFIGURATION"

WILLIAM MEISSNER (1976)

AND THEN PROJECTING ONTO THE THERAPIST THE "COMPLEMENTARY" POLE

MODEL 3 ALSO INVOLVES THE THERAPIST'S "USE OF SELF" TO MODIFY THE PATHOGENICITY OF "UNPAIRED" TOXIC "BOLUSES" THAT THE PATIENT HAS NOT YET BEEN ABLE TO ASSIMILATE INTO HEALTHY PSYCHIC STRUCTURE

FOR EXAMPLE, OVERWHELMING RAGE, EXCORIATING GUILT, OR INTOLERABLY PAINFUL GRIEF

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CLINICAL VIGNETTE
THE "SHARING" OF GRIEF

A PATIENT'S BELOVED GRANDMOTHER HAS JUST DIED

THE PATIENT, UNABLE TO FEEL HIS SADNESS BECAUSE IT HURTS "TOO MUCH," RECOUNTS IN A MONOTONE THE DETAILS OF HIS GRANDMOTHER'S DEATH

AS THE THERAPIST LISTENS, SHE BECOMES VERY SAD

AS THE PATIENT CONTINUES, THE THERAPIST FINDS HERSELF UTTERING, ALMOST INAUDIBLY, AN OCCASIONAL "OH, NO!" AND "THAT'S AWFUL!"

AS THE HOUR PROGRESSES, THE PATIENT HIMSELF BECOMES INCREASINGLY SAD

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PROJECTIVE IDENTIFICATION

IN THIS EXAMPLE, THE PATIENT IS INITIALLY UNABLE TO FEEL THE DEPTHS OF HIS GRIEF ABOUT THE GRANDMOTHER'S DEATH

BUT BY REPORTING THE DETAILS IN THE "MONOTONIC" MANNER IN WHICH HE DOES, THE PATIENT IS ABLE TO GET THE THERAPIST TO FEEL WHAT HE HIMSELF CANNOT – AND INSTEAD MUST DEFEND AGAINST

IN ESSENCE, THE PATIENT EXERTS "INTERPERSONAL PRESSURE" UPON THE THERAPIST TO TAKE ON, AS THE THERAPIST'S OWN, WHAT THE PATIENT DOES NOT YET HAVE THE CAPACITY TO TOLERATE

AS THE THERAPIST SITS WITH THE PATIENT AND LISTENS TO HIS STORY, SHE FINDS HERSELF BECOMING VERY SAD, WHICH SIGNALS THE THERAPIST'S QUIET ACCEPTANCE OF THE PATIENT'S DISAVOWED GRIEF
THE INDUCTION PHASE OF THE PROJECTIVE IDENTIFICATION

WE COULD SAY OF THE PATIENT'S SADNESS THAT IT HAS FOUND ITS WAY INTO THE THERAPIST, WHO, ABLE TO TOLERATE WHAT THE PATIENT FINDS INTOLERABLE, TAKES IT ON "AS HER OWN"

THE THERAPIST'S SADNESS IS THEREFORE CO – CREATED – IN PART A STORY ABOUT THE PATIENT (AND HIS DISAVOWED GRIEF) AND IN PART A STORY ABOUT THE THERAPIST (IN WHOM A RESONANT CHORD HAS BEEN STRUCK)

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PROJECTIVE IDENTIFICATION

THE THERAPIST, WITH HER GREATER CAPACITY TO EXPERIENCE AFFECT WITHOUT NEEDING TO DEFEND AGAINST IT, IS ABLE BOTH TO TOLERATE THE SADNESS THAT THE PATIENT FINDS INTOLERABLE AND TO PROCESS AND INTEGRATE IT
THE RESOLUTION PHASE OF THE PROJECTIVE IDENTIFICATION

THE THERAPIST "FEELS" IT BUT IS NOT OVERWHELMED BY IT

IT IS THE THERAPIST'S ABILITY TO TOLERATE THE INTOLERABLE THAT MAKES THE PATIENT'S PREVIOUSLY UNMANAGEABLE FEELINGS MORE MANAGEABLE FOR HIM

INDEED, THE PATIENT'S GRIEF BECOMES LESS TERRIFYING BY VIRTUE OF THE FACT THAT THE THERAPIST HAS BEEN ABLE TO CARRY THAT GRIEF ON THE PATIENT'S BEHALF

A MORE ASSIMILABLE VERSION OF THE PATIENT'S SADNESS IS THEN RETURNED TO THE PATIENT IN THE FORM OF THE THERAPIST'S HEARTFELT UTTERANCES – "OH, NO!" AND "THAT'S AWFUL!"

SUCH THAT THE PATIENT FINDS HIMSELF NOW ABLE TO BEAR THE PAIN OF HIS OWN GRIEF
– NOW ABLE TO CARRY THAT PAIN ON HIS OWN BEHALF –
– NOW ABLE TO TOLERATE WHAT HAD ONCE BEEN INTOLERABLE –

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THIS VIGNETTE
IS AN EXAMPLE OF
THE THERAPIST'S AUTHENTICITY
MODEL 3

AND NOT
THE THERAPIST'S EMPATHY
MODEL 2

IN OTHER WORDS
I AM SPEAKING HERE TO THE DISTINCTION BETWEEN
TAKING ON THE PATIENT'S UNASSIMILATED EXPERIENCE
"AS" THE THERAPIST'S OWN
WHICH IS WHAT HAPPENS IN THIS MODEL 3 EXAMPLE

AND TAKING ON THE PATIENT'S UNASSIMILATED
EXPERIENCE ONLY "AS IF" IT WERE HER OWN
WHICH IS WHAT HAPPENS IN MODEL 2

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