THE THERAPIST'S FAILURES OF THE PATIENT

1

UNLIKE MODEL 2, WHICH PAYS SCANT ATTENTION TO THE PATIENT'S PROACTIVITY IN RELATION TO THE THERAPIST,

MODEL 3 ADDRESSES ITSELF SPECIFICALLY TO THE FORCE FIELD CREATED BY THE PATIENT WHO – UNDER THE SWAY OF HER REPETITION COMPULSION AND FOR REASONS BOTH HEALTHY AND "NOT" –

IS EVER INTENT UPON RE – CREATING ON THE STAGE OF HER LIFE – THROUGH PROJECTIVE IDENTIFICATION –

THE UNMASTERED EARLY – ON RELATIONAL TRAUMAS

BY DRAWING THE THERAPIST IN TO PARTICIPATING IN WAYS SPECIFICALLY DETERMINED BY THE PATIENT'S EARLY – ON DEVELOPMENTAL HISTORY

PATRICK CASEMENT (1992)

INTERNALLY RECORDED AND STRUCTURALIZED IN THE FORM OF PATHOGENIC INTROJECTS AND "DYSFUNCTIONAL RELATIONAL CONFIGURATIONS"

2

IMPORTANTLY

CENTER STAGE FOR BOTH SELF PSYCHOLOGISTS AND RELATIONAL THEORISTS

ARE THE "INEVITABLE EMPATHIC FAILURES" OF SELF PSYCHOLOGY (MODEL 2)

AND THE "INEVITABLE RELATIONAL FAILURES" OF CONTEMPORARY RELATIONAL THEORY (MODEL 3)

BUT THE TWO MODELS CONCEIVE OF SUCH FAILURES VERY DIFFERENTLY

SELF PSYCHOLOGISTS (MODEL 2) **CONTEND THAT FAILURES ARE UNAVOIDABLE BECAUSE THE THERAPIST IS NOT** – AND CANNOT BE EXPECTED TO BE – **PERFECT**

3

BY CONTRAST

MOST RELATIONAL THEORISTS (MODEL 3) BELIEVE THAT THE THERAPIST'S FAILURES ARE A STORY ABOUT

NOT JUST THE THERAPIST AND THE THERAPIST'S INEVITABLE "LACK OF PERFECTION"

BUT ALSO THE PATIENT AND THE PATIENT'S INEVITABLE ENACTMENT OF HER UNCONSCIOUS "NEED TO BE FAILED"

SO THAT SHE CAN ACHIEVE BELATED MASTERY OF HER UNRESOLVED EARLY – ON RELATIONAL TRAUMAS

TO THAT END

THE PATIENT IS SEEN AS CONTINUOUSLY EXERTING "INTERPERSONAL PRESSURE" ON THE THERAPIST TO PARTICIPATE IN OLD "FAMILIAL AND THEREFORE FAMILIAR" WAYS

STEPHEN MITCHELL (1988)

RE – ENACTMENTS TO WHICH THE THERAPIST WILL FIND HERSELF CONTINUOUSLY AND UNCONSCIOUSLY REACTING

4

IN OTHER WORDS

THE RELATIONAL THERAPIST'S FAILURES ARE SEEN AS CO – CREATED

AS OCCURRING IN THE CONTEXT OF AN ONGOING AND CONTINUOUSLY EVOLVING RELATIONSHIP BETWEEN TWO "AUTHENTIC SELVES"

AND AS SPEAKING TO THE THERAPIST'S UNWITTING "RECEPTIVITY" TO THE PATIENT'S "PROVOCATIVE ENACTMENT" OF HER UNCONSCIOUS "NEED TO BE FAILED"

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PLEASE NOTE

THE IMPORTANCE OF THE THERAPIST'S CAPACITY BOTH TO TOLERATE "BEING SEEN AS BAD" (MODEL 2) AND TO TOLERATE "BEING MADE BAD" (MODEL 3)

IF THE MODEL 2 "EMPATHIC" THERAPIST CANNOT TOLERATE – AT LEAST EVERY NOW AND THEN – "BREAKING THE PATIENT'S HEART" (THEREBY AFFORDING THE PATIENT THE EXPERIENCE OF "GOOD – BECOME – BAD"),

THE THERAPIST WILL BE ROBBING THE PATIENT OF THE OPPORTUNITY ADAPTIVELY TO INTERNALIZE MISSING PSYCHOLOGICAL FUNCTIONS VIA "OPTIMAL DISILLUSIONMENT" AND "TRANSMUTING INTERNALIZATION"

SO TOO IF THE MODEL 3 "RELATIONAL" THERAPIST REFUSES TO PARTICIPATE AS SOMEONE WHO – AT LEAST EVERY NOW AND THEN – "INITIALLY RE – TRAUMATIZES BUT ULTIMATELY RELENTS" (THEREBY AFFORDING THE PATIENT THE EXPERIENCE OF "BAD – BECOME – GOOD"),

THE THERAPIST WILL BE ROBBING THE PATIENT OF THE OPPORTUNITY TO REWORK HER INTROJECTED BOLUSES OF TOXICITY VIA "SERIAL DILUTION" AND "RELATIONAL DETOXIFICATION"

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PARENTHETICALLY
IN THE PSYCHOANALYTIC LITERATURE

"INTERNALIZE"
TENDS TO IMPLY "POSITIVE"
AS IS TRUE FOR THE "TRANSMUTING INTERNALIZATIONS"
OF (MODEL 2) SELF PSYCHOLOGY

WHEREAS "INTROJECT"
TENDS TO IMPLY "NEGATIVE"
AS IS TRUE FOR THE "PATHOGENIC INTROJECTS"
OF (MODEL 3) CONTEMPORARY RELATIONAL THEORY

IN FACT
"INTERNALIZING GOOD" IS AT THE HEART OF
THE THERAPEUTIC ACTION IN MODEL 2

WHEREAS "INTROJECTING BAD" INFORMS OUR
UNDERSTANDING OF HOW MODEL 3 PSYCHOPATHOLOGY
DEVELOPS IN THE FIRST PLACE AND HOW IT
CAN THEN BE THERAPEUTICALLY MODIFIED

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MORE SPECIFICALLY
HOW DOES THE PATIENT "HANDLE" DISAPPOINTMENT?
HEINZ KOHUT (1966) vs W R D FAIRBAIRN (1963)

IN THE AFTERMATH OF DISAPPOINTMENT
KOHUT WRITES ABOUT "INTERNALIZING GOOD"
AS IT HAPPENS, THERE ARE "NO BAD OBJECTS" IN KOHUT'S FORMULATIONS
ONLY "STRUCTURAL DEFICITS" AS A RESULT OF "GOOD NOT INTERNALIZED"

IN THE AFTERMATH OF DISAPPOINTMENT
FAIRBAIRN WRITES ABOUT "INTROJECTING BAD"
AS THE "BURDEN" OF THE MOTHER'S "BADNESS" FALLS UPON THE PATIENT

HOW MIGHT WE RECONCILE THESE
TWO – DISCREPANT – PERSPECTIVES?

WE CAN USE KOHUT'S "TRANSMUTING INTERNALIZATIONS"
TO INFORM OUR (MODEL 2) UNDERSTANDING OF WHAT HAPPENS
IN THE AFTERMATH OF GRIEVING NON – TRAUMATIC DISAPPOINTMENT
THAT IS, WHAT HAPPENS WHEN THINGS GO RIGHT

WE CAN THEN USE FAIRBAIRN'S "INTROJECTION OF BADNESS"
TO INFORM OUR (MODEL 3) UNDERSTANDING OF WHAT HAPPENS
IN THE AFTERMATH OF TRAUMATIC DISAPPOINTMENT
THAT IS, WHAT HAPPENS WHEN THINGS GO VERY WRONG

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