

MODEL 2
**CORRECTIVE
PROVISION
"FOR"**

VS

MODEL 3
**AUTHENTIC
ENGAGEMENT
"WITH"**

1

1

MODEL 2 EMPATHIC ATTUNEMENT

THE MODEL 2 THERAPIST
– AS AN EMPATHIC SELFOBJECT –
"DECENTERS" FROM HER OWN EXPERIENCE,
JOINS ALONGSIDE THE PATIENT, AND
"TAKES ON" THE PATIENT'S EXPERIENCE

BUT ONLY "AS IF" IT WERE HER OWN
BECAUSE IT NEVER ACTUALLY
BECOMES HER OWN

2

2

MODEL 3 AUTHENTIC ENGAGEMENT

THE MODEL 3 THERAPIST
– AS AN AUTHENTIC SUBJECT –
REMAINS VERY MUCH "CENTERED"
WITHIN HER OWN EXPERIENCE AND
ALLOWS THE PATIENT'S EXPERIENCE
TO "ENTER INTO" HER

THEREBY TAKING IT ON "AS" HER OWN AND
ALLOWING HERSELF TO BE CHANGED BY IT

THE MODEL 3 THERAPIST "USES" HER "SELF"
TO FIND, AND TO BE FOUND BY, THE PATIENT

3

3

MODEL 2
 AS AN EMPATHIC SELFOBJECT
 THE THERAPIST PROVIDES
 A CORRECTIVE EXPERIENCE
 "FOR" THE PATIENT

MODEL 3
 AS AN AUTHENTIC SUBJECT
 THE THERAPIST PARTICIPATES
 IN A REAL RELATIONSHIP
 "WITH" THE PATIENT

4

4

AS IT HAPPENS
 THE THERAPIST'S PARTICIPATION
 AS AN AUTHENTIC SUBJECT
 MODEL 3
 WILL ALMOST INEVITABLY RESULT
 IN THE THERAPIST'S PARTICIPATION
 AS SOME VERSION OF
 THE "OLD BAD OBJECT"
 BECAUSE OF THE PATIENT'S EVER - PRESENT
 "COMPULSIVE AND UNWITTING" NEED
 - HER REPETITION COMPULSION -
 TO RE - CREATE THE EARLY - ON UNMASTERED
 RELATIONAL FAILURES IN THE HERE - AND - NOW
 ENGAGEMENT WITH HER THERAPIST

5

5

THIS "NEED TO BE FAILED"
 ASPECTS OF WHICH ARE "UNHEALTHY"
 ASPECTS OF WHICH ARE "HEALTHY"

WILL PROMPT THE PATIENT TO EXERT
 "INTERPERSONAL PRESSURE"
 JAMES GROTSSTEIN (1976)

ON THE MODEL 3 THERAPIST
 TO CONFORM TO THE PATIENT'S
 "RELATIONAL EXPECTATION"
 OF ENCOUNTERING "BAD"

AND SO IT IS THAT
 THE "RELATIONAL" THERAPIST
 - IN HER CAPACITY AS AN "AUTHENTIC SUBJECT" -
 WILL PARTICIPATE AS SOME VARIANT
 OF THE "OLD BAD OBJECT"

6

6

MORE SPECIFICALLY
THE REPETITION COMPULSION
 HAS BOTH UNHEALTHY AND HEALTHY COMPONENTS

THE UNHEALTHY COMPONENT HAS
 TO DO WITH THE PATIENT'S NEED
 TO HAVE MORE OF SAME

- NO MATTER HOW DYSFUNCTIONAL -
 BECAUSE THAT IS ALL
 THE PATIENT HAS EVER KNOWN

HAVING SOMETHING DIFFERENT WOULD CREATE ANXIETY
 BECAUSE IT WOULD HIGHLIGHT THE FACT THAT THINGS
 COULD BE, AND COULD THEREFORE HAVE BEEN, DIFFERENT

**BUT THE HEALTHY PIECE HAS TO DO WITH
 THE PATIENT'S NEED TO ACHIEVE BELATED
 MASTERY OF THE PARENTAL FAILURES**

7

7

"IF THE THERAPIST DOES NOT PARTICIPATE
 AS A NEW GOOD OBJECT,
THE THERAPY MAY NEVER GET UNDER WAY.

"BUT IF HE DOES NOT PARTICIPATE
 AS THE OLD BAD ONE,
 IT MAY NEVER END."

JAY GREENBERG (1986)

I WOULD WANT TO SUPPLEMENT THIS WITH
 "IF THE THERAPIST DOES NOT PARTICIPATE
 AS THE OLD BAD OBJECT,
THE THERAPY MAY NEVER GET UNDER WAY.

"BUT IF SHE DOES NOT PARTICIPATE
 AS A NEW GOOD ONE,
 IT MAY NEVER END."

MARTHA STARK (1994)

8

8

BOTH OF WHICH
 CAPTURE BEAUTIFULLY
 THE DELICATE BALANCE
 THAT EXISTS BETWEEN
 THE THERAPIST'S PARTICIPATION
 AS A "NEW GOOD OBJECT"
 SO THAT THERE CAN BE A STARTING OVER
 A "NEW BEGINNING" (MICHAEL BALINT 1987)

**AND THE THERAPIST'S PARTICIPATION
 AS THE "OLD BAD ONE"**

SO THAT THERE CAN BE AN OPPORTUNITY
 TO ACHIEVE BELATED MASTERY OF THE
 INTROJECTED RELATIONAL TRAUMAS
 AND THE "DYSFUNCTIONAL RELATIONAL DYNAMICS" TO
 WHICH THOSE INTROJECTED TRAUMAS HAVE GIVEN RISE

9

9

IN OTHER WORDS, OVER THE COURSE OF A TREATMENT,
**THE PATIENT SHOULD HAVE AN OPPORTUNITY
 TO EXPERIENCE HER THERAPIST AS BOTH
 A "NEW GOOD OBJECT" AND THE "OLD BAD ONE"**

MODEL 2 – STRUCTURAL GROWTH
 ADD NEW GOOD TO COMPENSATE FOR DEFICIENCY
 BY WORKING THROUGH
THE EXPERIENCE OF GOOD – BECOME – BAD
 ILLUSION FOLLOWED BY (AFFECTIVE) DISILLUSIONMENT
 "HOPE FOR GOOD" FOLLOWED BY
 "NOT AS GOOD AS WOULD HAVE BEEN DESIRED"

MODEL 3 – STRUCTURAL MODIFICATION
 CHANGE OLD BAD TO CORRECT FOR TOXICITY
 BY WORKING THROUGH
THE EXPERIENCE OF BAD – BECOME – GOOD
 DISTORTION FOLLOWED BY (RELATIONAL) DETOXIFICATION
 "EXPECTATION OF BAD" FOLLOWED BY
 "NOT AS BAD AS HAD BEEN ANTICIPATED"

10

10

AS WE HAD EARLIER DISCUSSED
**THE THERAPEUTIC ACTION
 IN MODEL 1 INVOLVES
 WORKING THROUGH
 THE STRESS OF GAIN – BECOME – PAIN**

AS DYSFUNCTIONAL DEFENSES
 – ONCE EGO – SYNTONIC –
 ARE REPEATEDLY CHALLENGED
 AND RENDERED INCREASINGLY
EGO – DYSTONIC

11

11

**BUT THE THERAPEUTIC ACTION IN MODEL 2
 INVOLVES WORKING THROUGH
 THE STRESS OF GOOD – BECOME – BAD**

AS THE PATIENT'S DEFENSIVE NEED TO CLING
 TO ILLUSION IS REPEATEDLY CHALLENGED AND
 GRADUALLY REPLACED BY MORE ACCURATE
 (AND SOBERING) PERCEPTIONS OF REALITY

**AND THE THERAPEUTIC ACTION IN MODEL 3
 INVOLVES WORKING THROUGH
 THE STRESS OF BAD – BECOME – GOOD**

AS THE PATIENT'S DEFENSIVE NEED
 TO CLING TO DISTORTION
 – THE SEDUCTIVE LURE OF THAT WITH WHICH ONE IS FAMILIAR –
 IS REPEATEDLY CHALLENGED AND
 GRADUALLY REPLACED BY MORE ACCURATE
 (AND LESS TOXIC) PERCEPTIONS OF REALITY

12

12

THE THERAPEUTIC ACTION IN MODEL 2
 WORKING THROUGH "POSITIVE TRANSFERENCE DISRUPTED"
 A STORY ABOUT "CONFRONTING"
 - AND "GRIEVING" -
 THE REALITY OF THE "LIMITATIONS, SEPARATENESS,
 AND IMMUTABILITY" OF THE PATIENT'S OBJECTS
BOTH PAST AND PRESENT
 "OPTIMAL DISILLUSIONMENT"
 "ADAPTIVE TRANSMUTING INTERNALIZATION"
 STRUCTURE - AND CAPACITY - BUILDING
**"INCREMENTAL ACCRETION OF PSYCHIC STRUCTURE
 AND ADAPTIVE CAPACITY"**
 "GRADUAL FILLING IN OF STRUCTURAL DEFICIT"
 EVENTUAL TRANSFORMATION OF THE PATIENT'S
 "RELENTLESS PURSUIT OF THE UNATTAINABLE"
 INTO "SERENE ACCEPTANCE" OF PAINFUL REALITIES
 ABOUT THE "OBJECTS OF HER DESIRE" 13

13

THE THERAPEUTIC ACTION IN MODEL 3
 WORKING THROUGH "NEGATIVE TRANSFERENCE"
 A STORY ABOUT "NEGOTIATING" THE VARIOUS
 "MUTUAL ENACTMENTS" AND "THERAPEUTIC IMPASSES"
 THAT WILL INEVITABLY ARISE AT THE
 "INTIMATE EDGE" OF "AUTHENTIC ENGAGEMENT" AS
 A RESULT OF THE PATIENT'S PROJECTIVE IDENTIFICATIONS
**THE THERAPIST'S PROVISION OF "CONTAINMENT"
 BY VIRTUE OF HER CAPACITY BOTH
 TO RELENT AND TO HOLD HERSELF ACCOUNTABLE**
 INCREMENTAL "RELATIONAL DETOXIFICATION" OF
 THE PATIENT'S "TOXIC INTERNAL BOLUSES" BY WAY OF
 "SERIAL DILUTION" AND BY VIRTUE OF THE THERAPIST'S
 CAPACITY TO PROCESS AND INTEGRATE ON BEHALF
 OF A PATIENT WHO TRULY DOES NOT KNOW HOW
 EVENTUAL TRANSFORMATION OF THE PATIENT'S
 "COMPULSIVE AND UNWITTING DRAMATIC RE-ENACTMENTS"
 INTO "ACCOUNTABILITY FOR HER DYSFUNCTIONAL
 ACTIONS, REACTIONS, AND INTERACTIONS" 14

14

IN ESSENCE
 MODEL 2
**"SERIAL ACCRETION"
 OF MISSING STRUCTURE
 TO CORRECT FOR
 "INTERNAL ABSENCE OF GOOD"**
 MODEL 3
**"SERIAL DILUTION"
 OF TOXIC STRUCTURE
 TO CORRECT FOR
 "INTERNAL PRESENCE OF BAD"** 15

15

PLEASE NOTE THE AGAIN CRITICALLY IMPORTANT
CLINICAL DISTINCTION BETWEEN

“POSITIVE TRANSFERENCE DISRUPTED”
AND “NEGATIVE TRANSFERENCE”

MODEL 2 **“POSITIVE TRANSFERENCE”**
NEED NOT BE WORKED THROUGH
ONLY ITS **“DISRUPTIONS”**
ACCOMPLISHED BY WAY OF
“GRIEVING THE REALITY OF DISILLUSIONMENT”
“OPTIMAL DISILLUSIONMENT” LEADING TO **“TRANSMUTING INTERNALIZATION”**

MODEL 3 **“NEGATIVE TRANSFERENCE”**
MUST BE WORKED THROUGH
ACCOMPLISHED BY WAY OF
“NEGOTIATING AT THE INTIMATE EDGE”
“SERIAL DILUTIONS” LEADING TO **“RELATIONAL DETOXIFICATION”**

16
