SAUL TUTTMAN

REGRESSION

Curative Factors in Dynamic Psychotherapy

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Regression: Curative Factor or Impediment in Dynamic Psychotherapy?[1]

Saul Tuttman

Many psychoanalytic theoreticians and practitioners consider regression to be among the important factors that may facilitate or impede growth in the process of dynamic psychotherapy. To some it is an inherent, unavoidable aspect of the process. Manifestations of regression may be considered a reflection of the analyst's limitations or of the patient's pathology. On the other hand, regression is sometimes looked on as a crucial factor in the therapeutic process leading to greater mental health.

The premises underlying psychoanalytic thinking are continually subject to question and reexamination (as well they should be). Among psychoanalytic constructs, the concept of *regression* and its ramifications have traditionally generated controversy and perplexity.

First, let us examine the word itself. "Regression" is defined by the *Oxford English Dictionary* (1971) as: "The act of going back; a return or withdrawal, to the place of origin ... a previous state or condition ... back in thought from one thing to another; from an effect to a cause; relapse,...

reversion to a less developed form…"

Two opposing implications of this definition seem apparent: first, the undoing of progress, and perhaps a deterioration; second, the return to fundamentals and origins that might facilitate a potential reorganization and better integration. Indeed, there is something highly paradoxical in a process that is often considered a central factor in the most serious pathology[2] and yet is acknowledged by many to be an important means of treatment!

Do our patients really show signs of such a process? Are there observations to be made in practice or in the experimental laboratory which relate to this notion? Does the concept apply to Margaret, a middle-aged married woman, who came to treatment complaining of unbearable self-consciousness and insecurity? Since childhood she has suffered severe chronic constipation and has had great difficulty in urinating. By the time a therapeutic alliance was established, it became apparent that Margaret develops paranoid feelings of being invaded and controlled and that she considers herself the victim of everyone's manipulations and intrusions.

One day in the course of her analysis, she recalled early memories of being an only child in a small town. Her father was a minister and her mother a respected home economist. These educated parents applied with gusto the Watsonian principles so popular in child rearing at that time. Margaret's

activities were carefully timed and structured. Mother and father were "pillars of the community," proud of the order and rigor in their lives. They were determined to have their daughter carry on the family traditions. Margaret was continually supervised and scrutinized by her parents, especially those days when she produced no bowel movement by bedtime! These self-sacrificing diligent caretakers would set the alarm clock for the middle of the night, then wake their daughter and place her on the "potty." They awaited dawn together anxiously. All three were exhausted, but the parents unrelentingly required the production of feces. Usually, the pressured child would not or could not produce.

In the following session, Margaret reported that after reexperiencing these memories, she had returned home (husband and son were not expected for several hours), placed a rubber sheet on the bed, removed her clothing and, in private, relaxed her sphincters and let it all out.

Was this "regression"? Was it therapeutic? Is Margaret getting healthier or more ill? Is it significant that this particular instance was not confined to the session and that careful control had been exercised by the patient to avoid harmful practical consequences of her *private* behavior? Was this act a regression or was it a progression toward a capacity to experience and explore her condition, which involved a previously repressed, ongoing regressive state that had been "acted out" in the external world without

restraint or understanding?

At times during her sessions, Margaret became very belligerent and accusatory toward the analyst; she complained that she was being degraded and controlled. Was this a sign of regression manifested within the transference? Could it be utilized therapeutically? How might such material prove beneficial for the patient?

There are many questions we might consider, among them:

(1) Are there relationships between the content, timing, pervasiveness, reversibility, therapeutic potential, and prognostic value of regression on the one hand, and the particular psychopathological state of the patient on the other?

(2) Are regressive manifestations recapitulations of earlier experiences? How can we know if they are? When are such states exploratory play that is encouraged or facilitated by the treatment? And can such "regressive" trends be useful in the treatment?

(3) When and how does regression lead to therapeutic change?

(4) What types of regression are helpful and what dynamics are involved?

(5) When do signs of regression in treatment represent a healthier

flexibility involving enhanced, adaptive reintegrative potential and when are they manifestations of a decompensatory breakdown in control?

Historical Perspectives and Review of the Literature

The notion of regression is considerably older than psychoanalysis. Plato (*Timaeus*) believed that "disease may be due to a reversal of the formation of the structures" (Jowett, Ed., 1937, p. 8) or bodily tissues. Darwin (1871) occasionally employed a concept of "reversion" or atavism somewhat akin to phylogenetic regression.[3] Nietzsche (1909, p. 40) conceived of man, when dreaming, as "brought back to" modes of mentation characteristic of prehistoric times.

Freud proposed several concepts concerning regression (see Arlow and Brenner, 1964; Balint, 1968). His first view, expressed in *The Interpretation of Dreams* (Freud, 1900), was an application of Hughlings Jackson's (1888) hierarchical-evolutionary neurological schema. (Freud [1891] had also applied this schema earlier, in *On Aphasia*.) Freud's concept of "temporal regression" was based on the assumption that the gradual psychological development from simpler, primitive, stages toward more complex, organized levels is undone by regression. The concept of reversal of genetic development became one of the cornerstones of psychoanalytic theory.

Another concept of regression—topographic regression—also appears in *The Interpretation of Dreams*. In order to explain the hallucinatory quality of dreams, Freud adapted the reflex-arc model. He proposed that, in waking states, excitation ordinarily begins as a sensory stimulus which passes from unconscious through preconscious to conscious thought, terminating in motor action. The regression toward the unconscious sensory imagery accounts for the hallucinatory nature of dreams.

Originally "borrowed" from biology, regression has gradually acquired meaning as a defensive and adaptive mechanism (e.g., in dreaming, avoiding stress) and as an element in pathogenesis (e.g., in hallucinations, infantile behavior).

Freud (1914) stated that, in retrospect, he had come to realize that during his early studies on hysteria, the turning backward in time found in patients' associations was a characteristic feature of neurosis. "Psychoanalysis could explain nothing in the present without referring back to something in the past and thus analytic technique that neglected regression would render scientific study of the neurosis impossible" (pp. 10-11).

Temporal and topographic regression gradually found their way into theory of psychoanalytic technique. As Freud formulated newer *theoretical*

constructs involving progressive developmental aspects, still other forms of "backward movement" could be conceptualized. Consequently, as the psychosexual theory evolved, instinctual or libidinal regression was postulated. Similarly, energic, structural, and ego regressions have been described.

More recently Kohut (1971, 1977) proposed that there is a developmental pathway leading to mature narcissistic self-cohesiveness. Consequently, his treatment for narcissistic pathology involves "working through" the infantile states of narcissism in treatment (Tuttman, 1978).

Peto (1967) goes back to the first case in the history of psychoanalysis (Anna O.; see Breuer and Freud, 1893-1895) to show the dangers and benefits of regression. The problems led to Breuer's abandoning the patient. Only much later did Freud (1912) recognize the Scylla and Charybdis of "good" and "bad" regression. He sensed that the regressed transference could be a most potent resistance. And yet he acknowledged that in the transference certain patients repeated their forgotten past, which was otherwise inaccessible. This repetition was induced partly by the "new" technique of free association in the analytic situation. And so Freud referred to regression as an ally in analytic treatment.

Still later, in 1914, looking back at the earlier Dora analysis, Freud noted

that in her treatment direct attempts to resolve the pathological effects of a recent trauma had failed and that Dora had had to make "a long detour, leading back over her earliest childhood" (p. 1); furthermore, he warned against the neglect of regression in analytic technique.

The tragic Freud/Ferenczi controversy more than forty years ago concerning the use of regression in treatment shocked the psychoanalytic community (Balint, 1968; Lorand, 1965). Ferenczi (1930, 1931) had continued his experiments with "active technique," work that Freud (1918) had originally supported. Ferenczi elicited the reactivation of what he considered to be vivid infantile traumas apparently involving significant child-rearing persons; and his patients craved reparation, comfort, and understanding. Ferenczi then experimented further. He wondered if the neutrality of the analyst might not repeat the attitudes of indifferent or neglectful parents. He therefore explored the possibility of reducing the tensions of these longings by responding positively; this new approach he called "relaxation technique" (Ferenczi, 1932).

Freud became distressed about the dangerous possibilities of arousing incessant cravings and frustration rather than "working them through" in accordance with the classical position (Peto, 1967). This clash between the "father" of the field and a brilliant pioneer—who died before the issues were clearly resolved—seems to have deflected conservative analysts from the

further study of the potential in Ferenczi's work. Exploration of the therapeutic use of regression in analysis was suspended, especially by "classical" analysts.

Balint (1968) pursued this subject in relative isolation, keeping in contact with several of Ferenczi's former patients. Balint noted Ferenczi's eventual awareness of the hazards and failings in his research; however, there were great theoretical benefits. The data obtained from patients when the analyst did not maintain "classical" neutrality elucidated the effects the analytic attitude can have on the particular transferences that are encouraged. Furthermore, the technical possibilities of countertransference interpretations and the importance of the analyst's reactions opened up a new area for consideration (Ferenczi, 1932).

One of the classical analysts, Kris (1934, 1952), formulated a new and important idea about regression, mainly during his investigations of artistic creativity. He distinguished two forms of regression: in one the ego is overwhelmed by regression; in the other regression is "manifested in the service of the ego." In the latter instance, a well-integrated person has the capacity to regulate and use creatively some of the primary processes. There appears to be a relation between the two forms of regression described by Kris and the work of Balint, yet there is a vital difference in their concerns; namely, Kris was interested in sublimation and artistic creativity as an

intrapsychic one-person psychological act, whereas Balint refers to a therapeutic regressive process occurring in a dyadic relationship.

Balint (1968) had carefully studied the value and dangers of regression. He conceived of regression as benign and beneficial in treatment when the analyst provides an accepting atmosphere in which the patient feels safe enough to regress "for the sake of recognition," understanding, and shared experiencing. In contrast, regression is malignant when the aim is libidinal gratification; which, Balint (1968) proposed, is quite similar to regression that overwhelms the ego (Kris, 1934, 1952).

Although Kris was to some extent concerned with the therapeutic uses of regression, he was primarily interested in its intrapsychic aspects and in brief regressive episodes in a single session with relatively resilient personalities or creative artists. Alexander (1956) differentiated those who regressed to a past trauma from those inclined to regress to pretraumatic satisfactory situations. Knapp (see Guttman, 1959) proposed that "for a psychoanalysis to be possible, an additional capacity must supplement 'regression in the service of the ego,' namely, 'regression at the behest of an object'" (p. 144), and in the analytic dyad that object would be the analyst.

For some years, members of the British school, namely, Little (1960), Winnicott (1960), Guntrip (1969), Milner (1969), and Khan (1974), focused

on regression as an important therapeutic tool. In addition, Fromm-Reichmann (1950), Sechehaye (1951), Rosenfeld (1965), and Searles (1965) have worked in this area. Most of these therapists have dealt with very serious pathology. In recent years Wangh (Weinshel, 1966), Boyer and Giovacchini (1967), Frosch (1967a, 1967b), Peto (1967), and Wallerstein (1967) have explored the analyst's share in promoting regression, and they question the analyst's technical responses as well. Gerald Adler (1974) and his colleagues conducted a symposium (Shapiro, 1974) at Tufts University that examined these issues impressively. Countertransference factors were given much consideration. Volkan (1976) discusses, among other things, regressive aspects of primitive internalized self- and object representations and how to treat them. This work is, in part, based on Kernberg's formulations (1975, 1976) and therefore relates to important developmental observations and theories of Anna Freud (1965), Mahler (1975), and Jacobson (1964) regarding progression and regression.

I shall not elaborate a long list of theoretical concepts to answer the question: Is regression necessary or desirable? I prefer to present the story of a patient's psychotherapy that I believe and hope will illustrate the importance of the question under consideration and its therapeutic ramifications—for the treatment of at least this type of patient. I shall intersperse relevant theoretical points as they seem applicable to the case.

Case Example and Discussion

Inge,[4] at age forty-seven, believed that she was losing her hair at an alarming rate. In desperation, she consulted dermatologists and endocrinologists. She could not accept their findings that the measured rates of hair loss and natural replacement were within normal limits. She became overwhelmed with despair and panic, and she was referred for psychiatric evaluation.

Inge was a petite woman of German birth. Before World War II, when she was ten, her Jewish parents arranged for their children's release from Nazi Germany to England, where Inge remained until coming to the United States. About twelve years ago, she married a man of similar background. They are childless. He works as a specialized technician and she is an executive in a research organization. Despite limited formal education, Inge is an intellectually developed, cultivated person who speaks with a charming accent combining the grace of English and the precision of German. Her gentle voice approaches the meek and tentative, though she can reach levels of deep tension, sarcasm, and intense rage.

During treatment it gradually became apparent that Inge lived a life of profound emotional isolation. She married her husband *because* she did *not* "love" him. Consciously, she believed her only hope for deep satisfaction in life could come from being uninvolved and "free." Her goal was to exist

surreptitiously in a perfect fantasy world uninterrupted by the pressures of the outside world. She went about paying "lip service," conforming to the routines with minimal energy. Aside from fantasy, her only interest was reading. She had never revealed to anyone the details of her secret world, although she does admit that as treatment progresses she lives less and less in fantasy.

This observation is granted grudgingly, with an air of both relief and wistful contemplation. There are indications to support her observation. For example, more effective work functioning resulted in a pay raise, praise, and a promotion to a complex, highly responsible position. Furthermore, an interest in my office plants—initially hampered by expressed feelings of futility and apprehension about her capacity to care for anything—has developed into an elaborate and gratifying hobby. It sounds as though she has become quite expert in the real world, at least as far as caring for exotic temperamental plants is concerned!

Despite these signs of greater participation and gratification via investments in the "outside," it remained difficult to know how Inge felt because of her almost endless guarded qualifications and obsessional "contortions." For example, she often states:

> I cannot tell you how I feel because (1) if I do I *may* be unfair or incorrect —I can be vicious and hostile; (2) it will show you how awful I am and you will surely send me away; (3) furthermore, it will hurt you because I can

> see so clearly how inept and incompetent you are; (4) you may misunderstand and conclude incorrectly that I care for you or need you. In actuality, I am utterly indifferent and unconcerned about you.

She also made it clear that she considered herself stupid, dull, unworthy, and guilty. She was certain that I was critical, hostile, and disgusted with her. Her attitudes and moods were usually submerged, and she appeared bland and indifferent. As she became more comfortable or felt more provoked in treatment, her mood swings and shift in attitudes were indescribably extreme.

Details of her past history emerged slowly. Her father was an accountant and her mother a housewife. Father, as Inge recalled, would become enraged when not obeyed. Mother was "proper" and felt strongly about children's compliance and responsibilities. When Inge was eighteen months old, a sister was born. The little infant was colicky and demanding. Inge became angry and assaultive toward the newcomer and her mother would threaten to leave if Inge misbehaved by expressing anger. There was a brother (the oldest child) two years older than Inge, and the father was particularly harsh toward this son, who was to supervise the younger siblings. When her father was punitive toward the brother, Inge felt especially guilty.

When it was time to buy a pair of shoes, Inge reports, her parents took her to the store and a tight-fitting pair was offered. The child remained silent

and suffered the pinching, feeling martyred and secretly enraged despite everyone's inquiries as to the fit; Inge responded that they felt fine.

Within the treatment situation, every time a telephone rang, she became morose. Every time a sound reflecting movement, breathing, or swallowing emanated from the therapist, Inge showed signs of profound tension. She tried to stifle her reactions but it was apparent to her that I could feel her reactions. Along with denial of all feelings, Inge released volcanic rage—despite her gigantic efforts to squelch it. She "accused" me of reading newspapers, preferring telephone talk with others—anything but listening to her! I was a hypocrite, a noncaring, self-centered, sadistic, "phony" doctor feigning an interest; but, then again, who could care for anyone as stupid and worthless as she? I even "cheat" her of time from her sessions; naturally I cannot stand her, but how hypocritical of me not to admit it and let her go, free her from this confusion and contradictory "mess" of our weird, unrealistic, chaotic "nonrelationship"! She pleaded with me to "let her go," but she kept her appointments regularly.

When Inge's rage and fear became unbearable, she would jump up and run out of the office, hurling curse words and shrieking that she would *never, never* come back! Sometimes she would become very morose and silent and then, a few hours after the session, leave a telephone message to the effect that she would have no more sessions as of now—good-bye forever! A few

days later she would phone and meekly ask if I could see her immediately. I structured the situation by informing her that I would continue to hold her appointment hours for her—even if she said good-bye—for a while, at least, in case she decided to come back and explore things further. In this way, I reasoned to myself, I could reassure her that I was reliable and would not retaliate or mirror her behavior if she needed to experience "killing me" in rage; that a safe ongoing situation was possible in treatment despite her stormy reactions and harsh attacks.[5]

Inge's intense reactions, manifested gradually in treatment, impressed me as being part of the regressive transference expressions of someone who had developed a false self-organization, someone who had experienced cumulative traumata and a deep-rooted sense of helplessness and distrust. The regressive pull was frightening; Inge especially feared (1) the surfacing of primitive impulses and feelings, and (2) the temptation to take a chance by admitting her needs and emotions. The confusion about which of us (if either) was sincere, genuine, or worthwhile probably reflected a regressive dedifferentiation (of mental self-representations from her mental representations of others) that was further blurred by primitive splitting and projection.

This patient was torn between living a pseudolife—by attempting to bury all self-awareness—and taking the risk of looking back and experiencing

and sharing her memories, accumulated pain, hate, guilt, shame, and neediness for emotional support and sensual contact.

Her initial caution—even in the form of negation—and her controls (though somewhat brittle) had reassured me of her ego strength. She had somehow been able to "contain" herself appropriately enough to go through the motions of living. Her dissatisfaction with the status quo was also encouraging. Despite her denial, I experienced the subtle beginning of a working alliance and gradually developing self-observation in the quality of her nonverbal response to my attentive presence. Despite her accusatory rage and craving for gratification, there were signs of hidden pleasure and relief whenever she was able to share feelings, to "be" and to be recognized! These signs indicated a positive prognosis for a therapeutic regression (Balint, 1968) despite Inge's probable borderline status in Kernberg's (1972, 1975, 1976) terms.

From time to time, Inge might say, "I must tell you something, but I cannot—I won't ... it is so terrible. Surely you'll reject me. I'm so wrong and you will be contemptuous." She would repeat this theme over and over.

As a Jewish schoolgirl growing up in Nazi Germany, she had experienced the Nazi movement as it infringed on daily life. She was forced to leave public school. Every day fathers of her friends disappeared. She recalls running

home from school and feeling ritually compelled to touch the stones of a particular government building en route. This magical gesture was her only means of ensuring that the Gestapo had not taken Papa away. The family maid, a loyal "Aryan," had worked for Inge's family for many years. And now the family became frightened of this housekeeper's potential for making serious trouble, so they cautiously avoided making her angry or jealous.

The atmosphere became increasingly ominous and the family tried unsuccessfully to leave the country. Finally, it became possible for Jewish children to leave Germany unaccompanied by their families. Inge felt frightened and happy at the same time. She claims to have been particularly pleased that she was sent to live with a foster family in an English city some distance from her sister and brother. The foster family was kind and accepting. When letters arrived from home, the child diligently replied; however, her parents' plea that their daughter ask the foster family to request visas for her mother and father was something Inge ignored. She felt ashamed and guilty about this, but she so valued being accepted that she wanted to forget the old home relationships in Germany and her foreign roots. She could not bear the possibility of her parents arriving; furthermore, she desperately feared that her request for their visas would be rejected by her foster family. Life was becoming quite pleasant and she felt "at home"; nevertheless, the secret guilt was intense and became even stronger when the letters from Germany ceased. After the war, documentation made quite clear her parents'

fate in the concentration camps; and Inge considered herself to be their murderer.

Talking about this subject has been most painful for Inge and is often followed by verbal assaults against herself as well as against me.

Therapeutic Considerations

An understanding of the psychodynamics of severe characterological and early developmental states and fantasies aids the analyst in maintaining a monitoring role and an emotionally appropriate attitude. Despite the patient's provocations, accusations, misperceptions, and projections, a therapeutic sense of proportion becomes possible (Federn, 1952). Perspective about the historical roots of the patient's "acting out" and distortions helps moderate countertransference reactions. Of course, a great deal depends on the personality of the therapist; nevertheless, an understanding of the stereotypic, primitive, polarized introjects and defenses (which imprison and distort the patient's mental life) can help the analyst respond therapeutically.

Shortly after World War I, Ferenczi experimented with regression in treatment. His student, Michael Balint, appreciated the concept that inappropriate stimulation and lack of understanding by the early caretaker impeded the child's psychological growth and resulted in an internal sense of a "basic fault." Balint (1968) stated that these patients experience something

distorted or lacking in the mind, producing a defect "which must be put right" (p. 21). Unless there was a "harmonious, interpenetrating mix-up" (p. 66) between significant other and self (at the preverbal, preconceptual stage before differentiation)—unless the parent "fit" the child's needs (as the amniotic fluid "fits" the fetus, the sea "fits" the fish, or the air "fits" the lungs); unless there was an unstructured, need-gratifying, spontaneous nonconscious flowing-between—a "basic fault" and its consequent pathology would result.

Thus, meaningful therapeutic work necessitates an opportunity for the patient to regress to that psychophysiological matrix (Tuttman, 1979) of a time before boundaries and words. Verbalizations or explanations alone are probably meaningless in such a framework.[6] The "pretransference resistance" concept of Sechehaye (1951) and the "dread of surrender to resourceless dependence" of Khan (1974) are concepts based on the following insight: patients who lack the crucial "support systems" established in early life would automatically and inevitably respond with dread and avoidance to the reactivation of their frustrated dependency needs, which have remained deeply unfulfilled ever since early childhood.

Thus, the first task of the understanding analyst who has determined that a therapeutic regression is indicated is to establish a trusting therapeutic partnership that encourages the dissolution of resistances to the regression. Once the resistances have dissolved, the patient must be allowed to

experience acceptance and recognition. In this way, the treatment provides what was unavailable during the patient's early life.

Balint (1968), the major advocate of this approach, has been joined by other contemporary analysts who have become proponents of a kind of opportunity for regression in treatment. The focus is on the analytic atmosphere and the crucial dyads of (1) caretaker-child in early life and (2) analyst-patient in treatment. Related concepts are:

The "good-enough" facilitating environment, which involves the holding function of the mother or therapist and the availability of transitional objects and opportunity for play (Winnicott, 1960, 1971).

The "container" role of mother or therapist and the need to help establish links involving thoughts and feelings (Bion, 1977).

The basic unit of caretaker and dependent one (Little, 1960).

The protective shield (Khan, 1974).

The extrauterine matrix and symbiotic phase before individuation (Mahler, 1975).

The mirroring in self-discovery (Lacan, 1949).

The availability of a self-object and the opportunity for idealizing and mirroring (Kohut, 1971, 1977).

The importance of space, presence, and absence in development and treatment (Winnicott, 1960, 1971; Green, 1975, 1978): that is, in treatment, the patient needs an opportunity to experience a sense of self, both within his own psychological space and as apartness from others. Problems in these areas arose in early life in reaction to parents who could not allow the growing child psychological space by acknowledging everyone's need and entitlement to be present sometimes and absent at other times.

According to such concepts, the patient's illness developed early in life through "cumulative trauma" (Khan, 1974) related to the unbearable "misfit" between mother and infant-child. The assumption is that, as development proceeds, healthy growth requires fusion, followed by closeness, and finally, space; transitional experiences and play are prerequisites for healthy individuation (Winnicott, 1960; Mahler, 1975).

Green (1975) talks about our failures with such patients as a reflection of present limitations in our therapeutic understanding. We impose too many words too authoritatively on the patient, which may tragically parallel the mother's insensitive intrusiveness. Perhaps patients sometimes need a respectful—rather than intrusive—presence, one that permits a sense of

space.

> We are too rigid or too idealistic if we think that it is a question of transforming primary processes into secondary ones. It would be more accurate to say it is a question of initiating play between primary and secondary processes by means of processes … which have no existence other than that of processes of relationship [Green, 1975, p. 17].

In summary, skillfully accepting regression to the traumatic developmental phases where something needed for growth was missing, and then facilitating understanding and growth from that point forward via an analytic relationship with transitional, mirroring, nonautocratic, nonintrusive, and synthetic qualities are necessary steps in the treatment approach described above.

It should be noted that this approach to regression in treatment is not universally accepted. Another viewpoint challenges the contention that regression is essential if psychodynamic psychotherapy or psychoanalysis is to be more than merely supportive. For example, Gill (personal communication, 1979) doubts that patients need to become more regressed in the course of treatment than they were before. He proposes the possibility that persons who manifested regressive behavior in their life situation before treatment may display such behavior in therapy. The therapist may incorrectly attribute the expression of this regressive state to the influence of treatment rather than appreciating the pretreatment regressive inclination.

Gill strongly recommends that the patient's regressive fantasies and wishes be explicitly verbalized in therapy rather than manifested only in behavior. He objects to the viewpoint that a crucial part of treatment must involve a wordless, primitive interaction which is supposed to make up for infantile trauma. He acknowledges the importance of patient-therapist interaction (and he does not equate neutrality with an austere, distant stance). Nevertheless, he also presses for focusing on the meaning of the interaction as it occurs and for making the transference explicit. He rejects the contention that "some mystical silent union is required" (personal communication, 1979). Furthermore, he does not accept Balint's (1968) program involving regression to a psychophysiological matrix before boundaries and words since, in Gill's opinion, regression in treatment to such a time is simply impossible.

Spitz (1965) states that:

> [Some of the early life disturbances,] be they psychogenic affections or psychosomatic conditions, bear a striking resemblance to disturbances with which we are familiar also in the adult … these resemblances do not make the two, the disturbance in the infant and the psychiatric disease in the adult, either homologous or even analogous [p. 293],

Nevertheless, many ego psychologists (Blanck and Blanck, 1974) reiterate that the more disturbed personalities need to be understood and approached in relation to developmental failure; however, the psychic structure of the adult differs from that of the child and simplistic parallels are of limited value.

Jacobson (1964) summarizes the early-life psychophysiological matrix, the undifferentiated drive energies, and the "physiological discharge toward the inside, i.e., or the self' (p. 9). Schur (1955) refers to such psychophysiological discharge mechanisms that, in accordance with his theory of *somatization*, operate when there is a dedifferentiation of drives and of self- and object representations. Physical symptoms often result from such regressive processes; there may be reactivations of infantile manifestations involving various body organs for affect discharge. Schur proposes using treatment to promote verbalized, neutralized discharge of aggressive and libidinal energies, thereby relieving somatic symptoms with the concomitant progression of ego functioning toward meaningful "structural change."

The "somatization" Schur describes probably involves an archaic, preverbal body language that is "out of touch" with words and interpretations. Such somatic expressions probably refer to pre-ego manifestations that occurred early in life before language developed. Again, this brings up the question, Is preverbal experience retrievable? Somatic channels are probably more primitive and less accessible to speech and ideation than are motoric or "acting-out" phenomena. The issue of "reconstruction of preverbal experience" is debated in the literature (Blanck and Blanck, 1974). Anna Freud (1969) acknowledges the importance of preverbal experience but questions whether it is possible to work therapeutically with such material. She states:

> This means going beyond the area of intra-psychic conflict, which had always been the legitimate target for psychoanalysis, and into the darker area of interaction between innate endowment and environmental influence. The implied aim is to undo or to counteract the impact of the very forces on which the rudiments of personality development are based.
>
> Analysts who work for this aim assure us that this can be achieved [pp. 38-39],

But Anna Freud is dubious about working through preverbal issues in analysis. Dealing with such genetically archaic material differs from focusing on the ego's defensive maneuvers. She further questions whether the transference can "transport" the patient back to the beginning of life and concludes:

> [It] is one thing for pre-formed, object related fantasies to return from repression and be redirected from the inner to the outer world (i.e., to the person of the analyst); but [it] is an entirely different, almost magical expectation to have the patient in analysis change back into the pre-psychological, undifferentiated, and unstructured state in which no divisions exist between body and mind or self and object [pp. 40-41],

In summary, the ego-psychological position regarding treatment emphasizes the role of ego mechanisms of defense and attempted adaptation. Among the coping measures are: regression to a dedifferentiated state, energic diffusion, and the return to an early-life psychophysiological matrix where internal discharge and somatizations are prevalent. Patients undergoing such manifestations can be very demanding on the therapist. I believe that often a primitive, empathic alliance is necessary, with the

therapist's silent, unobtrusive presence and subtle but firm sensitivity providing "phase-specific," symbiotic support (Mahler, 1975) that aids the establishment of forestages of thought, communication, and identification. Some consider such an alliance impossible to achieve; others claim success.

Ego-psychological and object-relations theory may be applied to the patient-analyst dyadic interaction in an effort to "work through" ego deficits —or what Federn (1952) called "ego lesions"—which had developed as a result of deficiencies in the early-life child-parent dyad. For example, Mahler's (1975) concept of the infant's initial symbiotic state and subsequent subphases leading to individuation may provide guidelines for treatment approaches.

One hopes that practitioners use analytic interpretation and empathically facilitated regression-reconstruction in appropriate combination when applying the therapeutic framework proposed in this chapter to work with severely disturbed patients. In my opinion, the interpretive-neutral model alone cannot be used in the treatment of severe character disorders, borderline cases, or psychotic patients without generating overwhelming resistances. For example, the therapeutic application of a theory that of necessity focuses on and emphasizes the patient's split-off rage, assaultiveness, and hate would—perhaps inevitably—arouse guilt, resentment, and possibly a masochistic stance or a sadistic

"counterattack." Such reactions would be most likely to occur when the patient is projecting unconscious rage while in a state of confusion regarding the "bad" split-off self-objects.

All too often such a patient experiences an interpretation about "split-off" rage as if the analyst were saying, "Patient, you are bad. The hate is in you while I am knowing and good! You, patient, want to devour and kill, and then blame it on me—the good, innocent doctor." Thus, we become trapped in a vicious circle: the patient projects hate, envy, and rage into the analyst; the analyst then interprets these feelings and appears to "deposit" hate, envy, and rage into the patient. Even if such interpretations are accurate, we must keep in mind the difference between explaining and understanding (Kohut, 1977).

Sometimes a less verbal, less interpretive focus might help in such stalemates. For example, one might listen quietly when acknowledging the patient's aggression and interpret—when necessary—with an understanding emphasis. The analyst could empathize with the subjectivity of the patient—with his or her particular historical drama of rage and despair.

Inge was inclined to feel tremendous responsibility and guilt about her early-life rage, jealousy, greediness, and failure to "rescue" her parents. I accepted these feelings as profoundly painful and encouraged her to examine with me, why, given her background and life circumstances, she had reacted

as she did.

As a very young child, Inge did not experience a crucial kind of unconditional acceptance—one that transcends issues of right or wrong, guilt or innocence, good or bad—a space in which to feel anything, to experiment and to ventilate; a beginning sense of identity wherein there flows the broad spectrum of human impulses, thoughts, and emotions. It is invaluable for children to have their feelings and thoughts accepted and reflected by their caretakers. Human beings *do* feel jealous and enraged.

Of course Inge experienced such feelings when, as a hungry, unfulfilled young child who craved attention and nurturance, a newcomer suddenly appeared and attracted maternal care with her colicky demands. Parental mirroring and understanding of Inge's feelings, drives, and "selfness" might have helped. But Inge's parents apparently were not able to provide such understanding; instead they overdisciplined her—at least, so it felt to her.

If an atmosphere conducive to exploring regression and recapitulation within the therapeutic alliance is not present, the patient often experiences the analyst as detached, accusatory, hostile, and superior. And yet, unless the projections and split-off impulses and feelings are appropriately interpreted, their contaminating effects may interfere with the patient's developing enough trust in the analyst to risk therapeutic regression, feel nurturance,

and gain meaningful understanding.

Were there reasons Inge experienced her therapist as a noncaring hypocrite who rejected her? Were her observations and conclusions accurate? Could she have misperceived his reactions? Was the press of her own overwhelming neediness for more than full attention related to her past experiences? Was her obsession with controlling people and circumstances related to her unbearable early-life feelings of powerlessness (and compensatory fantasized omnipotence)? Did the damming up of a lifetime of rage and guilt contribute to her misperceptions of me and our relationship? Did she fear her need to bring up all of these dreaded unresolved issues of the past again? Did her ill will and nihilism make for a safer situation than daring to hope and revive vulnerable dependency states?

Gradually, Inge dared explore the frightening risks involved in sharing her magical fantasies and self-protective rituals. With great pain and hesitation, she reluctantly admitted secrets. For example, each session she *had* to place her pocketbook on a particular part of the Oriental rug in the office. She disclosed a fear that I or her husband would die unless she engaged in rituals that would somehow "protect" us from harm. It petrified her to admit these rituals, since exposing them verbally might in itself dissipate the protective "magic" of the compulsive act. At the same time she felt humiliated at her irrationality and ashamed of her aggressive wishes.

Finally, she courageously decided *not* to allow herself a particular movement (walking down the curb of a sidewalk in a "special" way while twisting her head so that she could look at a certain signpost). It frightened her to relinquish these protective devices, although she resented the imprisoning effects of such actions, which had dominated her life. It was frightening to contemplate finding that all of this suffering had been unnecessary and ineffective in influencing fate. The positive therapeutic alliance (despite her ambivalences) and her willingness to trust me enough to share her infantile, primitive thoughts and affects served her struggle to overcome lifelong constrictions.

The dramatic interplay of progression and regression developed in a later phase of Inge's treatment which involved risk-taking and the reexperiencing of a most painful early memory.

In addition to caring for her exotic home garden, Inge ventured forth and bought a puppy. She had always wanted a pet and yet dreaded the possibility. From her view, it was an awesome responsibility: she and her husband lived in a small city apartment; both worked all day. How would she "train" this exuberant, impulse-ridden "baby"? He was irrepressible, not even housebroken, teething, quite stubborn and playful. She felt joy along with apprehension; when the pet barked noisily, scratched, snapped, and soiled the house, all was chaos. Inge was enraged—there was no order or

gratification. She blamed the dog, herself, her husband, and me; she attacked herself for wanting the puppy, for loving it, for hating it, for keeping it, and for wanting to get rid of it. Finally, in desperation, she gave up. She arranged for a family who lived in the country to adopt the animal. At this point, Inge assaulted herself—her disloyalty, treachery, irresponsibility, and shallow values. The parallels with her own childhood became apparent.

As a child, none of Inge's instinctual or aggressive expressions were indulged; any such manifestations were greeted with rejection and threats of parental abandonment. It seems that the pup encouraged a regressive reactivation of naive mental representations of early life. Inge played the role of the harsh, righteous parent toward the instinct-laden child/puppy. At the same time (true to infantile relationships), she manifested a fluidity of boundaries and a lack of self-cohesiveness. Thus, she shifted her role and identified with the fun-loving, self-indulgent, and assertive creature doomed to be abandoned.

This fluidity of boundaries also permitted a regressive transference in which there were confused oscillations. One moment I was the analyst-tyrant and she was the guilty child-patient; the next second she was the attacking, righteous patient-parent and I the condemned, "bad" analyst-child. Her desertion of the beloved and hated dog also paralleled her failure to rescue her parents. Although most painful, such aspects of treatment provide a

climate for meaningful ventilation and for exposing and exploring fragmented regressive components. Active mastery and better integration become possible when regression in treatment makes accessible previously repressed and split-off, conflict-laden misperceptions and distortions from early life. These primitive affects and infantile defensive patterns had cheated the patient of a freer, fuller life.

Guidelines for the Practitioner and Conclusion

It has been my experience that regression in treatment affords many patients a new chance to make crucial material accessible to consciousness—to the "observing self' that is developing in alliance with the analyst. As a consequence, a productive experience often ensues. Both participants cope with "the unfinished business" of fragmented percepts and primitive longings, hurt and rage, anxious confusion and early-life maladaptive coping patterns. Here is the opportunity for the "truer self' (Winnicott, 1960) to emerge.

The analyst's sensitivity to countertransference phenomena is crucial in establishing an atmosphere that permits therapeutic regression. The analyst's capacity to accept ambiguity, neediness, and intrusiveness is also important. A patient's "reactivated" craving for fusion, fear of disintegration, and accusatory rage often challenge the therapist's sense of security. The regressive fantasies can involve needs to "kill the object," to play with

illusions, to create distance or absence, and to feel murky blending or transitional states. Such behavior may prove disquieting to the analyst, depending on his particular problems and conflicts.

A patient's regressive behavior often evokes strong countertransference reactions. The emotional predicament of the analyst may parallel the caretaker's position, as elaborated by Benedek (1959) in her description of "Parenthood as a Developmental Phase." Like the parent and child, the analyst and patient also make up a dyad. Thus treatment ideally can offer a parallel of the mother-child "facilitating environment" (Winnicott, 1960). This analogous recapitulation may prove therapeutically vital, whether or not the patient precisely reduplicates the specifics of the past in the regressive experience in treatment.

I have stated the reasons why I consider regression to be potentially productive in psychoanalysis; however, I do not advocate a "milk-giving, hand-holding," libidinally gratifying interaction. Such an interaction often leads to more malignant pathology (insatiable and sometimes irreversible regression) rather than achieving our objective, that is, enhancing perspectives, insight, and integration.

I do not maintain complete neutrality *at all times in all cases*. There are some pathological states that require modified technique. For example,

sometimes the analyst's overt expression of particular countertransference feelings proves to be essential and productive. Such positions may be observed in the work of Sechehaye (1951), Winnicott (1960, 1971), Searles (1965, 1979), and Hoedemaker (1967).

I did not consider the issue of regression a simple matter. There are serious dangers and many things we do not understand. Our diagnostic and prognostic judgments are somewhat primitive and too often postdictive. Our comprehension of what produces change in the analytic dyad requires further investigation. It is encouraging that consideration is devoted to these issues today. It seems to me that, in the past, all too often an extreme predilection toward either the "intrapsychic" or the "interpersonal" bias created an artifact. In my opinion, human development and psychoanalytic treatment can be most effectively understood via exploration in the therapeutic dyad of the ramifications of the early-life interpersonal *and* intrapsychic interactions which lead to intrapsychic representations and eventual intrapsychic structures and interpersonal relationships.

I hope we will follow Balint's courageous research and investigate more thoroughly those painful examples of failure in treatment where regression took on malignant qualities. We might examine Khan's (1974) hypothesis that a hidden, misunderstood dread of surrender to resourceless dependence often underlies malignant regressions.

It is difficult for those therapists who acknowledge the importance of regression in treatment to deal with the inevitable stresses and demands involved.

It is difficult for our patients to dare to reopen dreaded, hidden areas of indescribable trauma resulting from the unavailability of vitally needed "support systems" in early life.

We imperfect practitioners try to keep prearranged appointments completely regulated by calendar and clock. We do our best to listen patiently and sincerely, although it is inevitable that we listen selectively and defensively. We strive to be open and receptive despite our predilections and prejudices. We do not and cannot provide unconditional love and the superhuman availability our patients often crave. The latter "failing" is probably all for the best, since such "ideal" fulfillment would hardly prepare our patients to become more adaptive to the realities of life. Furthermore, the fear of obliteration through intimacy and fusion is also frightening to many of our analysands. There is more than one Scylla and Charybdis through which we must chart our adventurous dialectical course.

How can we do better? I suspect our theory and technique would benefit greatly from further elucidation of the nature and developmental role of: transitional phenomena and objects, play and illusion, presence and

absence, and "facilitation" and "holding." I consider these factors to be crucial in the working through of the therapeutic regressive interaction between patient and analyst—or perhaps we might call this aspect of the dyad "me and not me." Is it too far-fetched to think of the Janus-like unique creation of the psychoanalytic encounter as a dyad and, at the same time, much more than a couple—for, at least at times, we have present in our consulting room a living *triad*: patient, analyst, and patient-analyst.

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Notes

1 An earlier version of this chapter was presented at the Annual Meeting of the American Academy of Psychoanalysis, Atlanta, Georgia, May 1978, and appeared in the *Journal of the American Academy of Psychoanalysis.* 7:111-131, New York: Wiley, 1979.

2 E.G., Balint's (1968) "malignant regression" and Arieti's (1959) "progressive teleological regression."

3 Stanley Jackson's (1969) scholarly work offers a more thorough discussion of the intellectual climate that probably influenced Freud's thinking as he developed his regression concepts.

4 Niederland (personal communication, 1979) reviewed this case and provided insights relating to his work on obsessional characters (1960) and Holocaust victims (1961).

5 Hoedemaker (1967) and Winnicott (l960, 1971) explore the therapeutic use of anger in treatment.

6 Could there be some relationship between these concepts and the cerebral-cortical specialization data discussed by Bogen, Mandell, Knapp, and others at the May, 1977, meetings of the American Academy of Psychoanalysis in Toronto, Canada?