Chapter 24

Therapeutic regression, primary love, and the basic fault

In the previous Part we have found that regression, as observed in the analytic situation, may have at least two aims: gratification of an instinct or drive and recognition by an object; in other words, it is both an intrapsychic and an interpersonal phenomenon. We also found strong indications that for the analytic therapy of regressed states its interpersonal aspects were more important.

The problem at which we have arrived here may be termed 'the healing power of relationship'. Although, as a rule, it is not stated quite so explicitly, we are compelled to recognize that the two most important factors in psychoanalytic therapy are interpretations and object relationship. It should be borne in mind, however, that with the latter we are on comparatively unsafe grounds because psychoanalytic theory knows much less about it.

We have some systematic knowledge about the instincts or drives and their vicissitudes, about the structure of the mind and the various defensive mechanisms working in it, and also about the role of conflict in psychopathology. It was on these three pillars — the theory of the instincts, of the structure of the mind, and of the pathogenic effects of conflicts — that Freud based his technical recommendations. The aim of his technique was to make the unconscious conscious — or in a later version: where id was, ego shall be — and the tool for achieving this aim was almost exclusively interpretation. Although as early as 1912 and 1915 in his two papers on Transference, he stated in so many words that transference, that is an object relationship, may have considerable healing powers, he evidently mistrusted them, and never considered them worthy of a proper study. In consequence, interpretation became accepted as far the most important technical measure.

As I tried to show in Part IV, putting all the emphasis on the
The regressed patient and his analyst

The regressed patient and his analyst

analyt's interpretative work amounted, perhaps, to an over-simplification. This worked as long as we were able to select from all the people, who asked for analytic help, those who without much difficulty could adapt themselves to the analytic setting created by us according to Freud's early papers on technique (1911-15). As long as this setting was accepted as obligatory for all of us, the analyst's work could be considered as consisting almost solely of interpretations.

However, if we recognize that the setting recommended by Freud represents only one of the many possible settings—that is, it is a sort of primus inter pares—a new task emerges for us which is to find other settings in which analytical work with less strictly selected patients can profitably be carried out. This task has a special importance for patients in regression.

To repeat what we have found in the previous chapters, in certain periods of the treatment, creating and maintaining a workable relationship, particularly with a patient in regression, is perhaps a more important therapeutic task than giving correct interpretations. Possibly something like this was in Freud's mind when he wrote about the therapeutic effects of transference. However, as just mentioned, his interest was centred chiefly on the intrapsychic processes that may have therapeutic effects, and he did not pay much attention to the interpersonal phenomena and their possible effects on therapy.

But, whatever the case may be, interpretations are, of necessity, always verbal. Although one of their principal aims is to help the patient to have feelings, emotions, and experiences that he was incapable of having before, they demand intellectual understanding, thinking, or a new 'insight'. All of these descriptions have close connections either with 'seeing' or 'standing', that is with phallic activities, which can be performed alone. In contrast, object relationship is always an interaction between at least two people and, more often than not, is created and maintained also by non-verbal means.

It is difficult to find words to describe what it is that is created. We talk about behaviour, climate, atmosphere, etc., all of which are vague and hazy words, referring to something with no firm boundaries and thus reminiscent of those describing primary substances.

In spite of the fact that the various forms of object relationship cannot be described by concise and unequivocal words, that is, the translation of the various object relationships into words must always be subjective, arbitrary, and inexact, the 'atmosphere', the 'climate', is there, it is felt to be there, and more often than not there is even no need to express it in words—although words may be an important contributory factor both to its creation and its maintenance. In contrast to 'insight', which is the result of a correct interpretation, the creation of a proper relationship results in a 'feeling'; while 'insight' correlates with seeing, 'feeling' correlates with touching, that is, either primary relationship or ocaophilia.

Returning now to our main topic, regression, it was its intra-psychic aspects that remained in the focus of Freud's interest throughout his life. One reason, perhaps, for this comparative neglect might be that at the time when he described the regressive forms of transference, his instinct theory was practically finished; the third edition of his Three Essays on Sexuality appeared in 1915, that is the same year in which he published his paper 'On Transference-Love'. On the other hand, a developmental theory of object relationship was at that time in its earliest beginnings.

It was on his instinct theory that Freud based his often-quoted therapeutic recommendations that the analyst should not respond positively to a regressed patient's 'cravings', in particular, should not satisfy them. The analytic therapy must be carried out in the state of 'abstinence', 'frustration', or 'privation'. In many ways this recommendation is correct. If the analyst does not do anything else apart from gratifying his regressed patient's cravings, his action cannot but produce temporary results. Since the source of the cravings has not even been touched, after a while new cravings will appear demanding, equally strongly, new gratifications. If then the analyst, influenced by the blissful peace immediately following his action, is induced to experiment with further gratifications, a never-ending vicious spiral may develop which is not uncommon in regressed states.

Thus, responding positively to a regressed patient's longings and cravings by gratifying them, will be very likely to prove a technical error. On the other hand, responding to a patient's needs for a particular form of object relationship, more primitive than that obtaining between adults, may be a legitimate technical measure which possibly has nothing to do with the rule of 'frustration' or 'privation'.

But, if we accept this idea, we leave the boundaries of instinct or drive theory, which belongs to the sphere of one-person psychology,
The regressed patient and his analyst

and enter the realm of two-person psychology. Whereas, on the basis of the former, we could maintain that both the form and the depth of regression are determined solely by the patient, his childhood, his character, the severity of his illness, etc., etc., in the latter we must consider them as the result of an interaction between the particular patient and his particular analyst. Concentrating for a moment on the analyst's contributions, that is, on his technique, we may say that the clinical appearance of a regression will depend also on the way the regression is recognized, is accepted, and is responded to by the analyst.

Perhaps the most important form of the analyst's response is interpretation; it may have a crucial influence on the treatment, whether the analyst interprets any particular phenomenon as a demand for gratification or as a need for a particular form of object relationship.

Supposing the analyst is prepared to consider regression as a request, demand, or need, for a particular form of object relationship, the next question will be how far should he go or, in other words, what sort of object relationship he should consider offering to, or accepting from, his regressed patient. This is an important technical problem and, as with almost every problem in psychoanalytic technique, it has several aspects.

The first aspect belongs to the borderland between one-person and two-person psychologies; it may be described as a problem of differential diagnosis. The analyst must be able to recognize which forms of object relationship will be adequate, or even therapeutic at this moment for his regressed patient. In order to do so, he must not only accept that these relationships exist and may have therapeutic effects but must also know enough of them to be able to choose the one with the best therapeutic possibilities.

With this we enter a controversial field. Some analysts firmly believe that only those forms of object relationship are compatible with a proper running of analytic therapy that allow the analyst to retain his role of passive, sympathetic objectivity described by Freud. I have the impression that they still feel that this is an absolute parameter, and if the analyst, for any reason whatsoever, abandons it, the treatment should no longer be called psychoanalysis. If this impression is correct, it follows that these analysts will probably maintain that this differential diagnosis is unnecessary, or even conducive to

Therapeutic regression, primary love, & basic fault

faulty, harmful technique. In Part III, in particular in Chapters 14 and 16, I discussed some of the consequences of this general policy.

In order to avoid a possible misunderstanding, it is important to realize that interpreting to the patient that he has always tried to establish a particular genital, or even pre-genital, relationship, is something utterly different from accepting, and working with, the fact that the patient at this particular stage needs a certain form of object relationship, and allowing him to create and maintain it in the analytic situation. However, in the cases of the better-known, later, object relationships, interpretations, as a rule, have enough power to start and to maintain a therapeutic readjustment to reality; in some cases there may come to be some 'acting-out' but this, too, can be dealt with by interpretations. Most of this class belong to what I called the Oedipal area, and thus the events occurring during them can be expressed fairly adequately in conventional adult language. The most important of them are – in reverse chronological order: the phallic-narcissistic form with its many variants, such as egotistic-self-assertive, aggressive-castrating, submissive, masochistic, etc.; the many anal-sadistic forms with all the over-compensations and reaction-formation belonging to them, and so on.

For the sake of completeness I must mention here the various oral forms of object relationship, summed up nowadays as 'oral dependence' which many analysts would include here as a matter of course. Since, in my opinion, 'oral dependence' is a misleading concept, may I sum up briefly my arguments against it.

The relationship that 'oral dependence' tries to describe is not a one-sided dependence, but an 'inter-dependence'; libidinally, the mother is almost to the same extent dependent on her baby as the baby is on her; neither of them may have this particular form of relationship and the particular satisfaction independently from the other. Though oral aspects constitute an important part of the whole phenomenon, there are various other factors present, and it is difficult to assess with certainty which is the most important. Furthermore, the mother's breast, the counterpart of the child's mouth, is about as often as not excluded by present-day nursing fashion – in most cases without seriously interfering with the mutual interdependence which, in my opinion, is the decisive factor in this relationship.

The interdependence should remind us that any attempt at describing this relationship using terms of one-person psychology will
The repressed patient and his analyst

necessarily be misleading. Although this is true up to a point for all relationships, the effect of interdependence diminishes at the same rate as the importance of the partner's cooperation. An instructive example is anal domination, the theory of which is perhaps the best developed in psychoanalysis. Here the cooperation of the partner is minimal, in consequence the relationship can be described adequately by terms belonging to one-person psychology. On the other hand, in genital love it is essential that an indifferent object whom we love should be changed by us into a cooperative partner. The relationship between an individual and his indifferent object can be described fairly well with our terminology, whereas the relationship between cooperating partners needs a new terminology belonging to two-person psychology.

A further important difficulty is that all primitive relationships belong, as a rule, to the pre-verbal period of development. As we have seen in Part I, phenomena belonging to this area do not lend themselves easily to verbal description. In what follows we have to bear these two difficulties constantly in our minds: the one caused by the intense interdependence of two individuals, and the second caused by the primitive nature of the developing relationship which is hard to render in adult conventional words.\(^1\)

After removing this obstacle, and the confusion created by it, we may return to our main problem: what sort of primitive, possibly preverbal, object relationships should the analyst consider accepting from, or even offering to, his repressed patient?

In the preceding chapters, in particular in 4, 12, 15, and 22, I

\(^1\) 'Oral dependence' is a relatively new concept. I could not discover any reference to it in Freud's writings, so it seems to be a post-Freudian, and most probably American, creation. I think it would be an interesting study to find out the exact history of its development. Here are a few data for it. 'Dependence' without the adjective 'oral' occurs a few times in Fenichel's textbook (1945). The first use of 'oral dependence' that I found was by F. Alexander in 1930. To my surprise I could not find it in Melanie Klein's writings; the first reference to it by her school seems to occur in New Directions in Psycho-Analysis (1955), a collection of papers written for Melanie Klein on the occasion of her seventieth birthday in 1952. Here too the adjective 'oral' was missing but the term 'dependence' referred to what today would be called oral dependence, the dependence of the child on his mother; the two authors using it were Paula Heimann and Joan Rivière. From about 1952, dependence, and even oral dependence, occurs with ever-increasing frequency in Winnicott's papers, but apparently not before that date.

Therapeutic regression, primary love, & basic fault

described in detail the characteristics of the three chief forms observed in my analytic practice. These were: (a) the most primitive, which I called primary love, or primary relationship, a sort of harmonious interpenetrating mix-up between the developing individual and his primary substances or his primary object; (b) and (c) oecophilias and philobatisms which form a kind of counterpart with one another; they already presuppose the discovery of fairly stable part and/or whole objects. For the predominantly oecophilic individual, life is safe only in close proximity to objects, while the intervening periods or spaces between objects are felt as horrid and dangerous. These phenomena have been known for some considerable time; recently under the influence of ethology they are referred to as 'attachment behaviour' (e.g. Bowlby, 1958). In contrast, the predominantly philobatic individual experiences the objects as unreliable and hazardous, is inclined to dispense with them, and seeks out the friendly expanses separating the treacherous objects in time and space.

The next question is, of course, what can a patient gain from regression? Why is it so important to him? As I have mentioned several times, not all patients go necessarily through a regressive period. That means that some patients can do without it, perhaps they do not even need it. However, it is difficult to get any indication about the distribution of those people who do, and those who do not, need a regressive period. The reason for this is that patients who go through an analytic treatment do not constitute a representative sample, because they have been selected according to their analyst's ideas about analysability. Still, there is perhaps some truth in the impression that in our present patient material the number of those who need regression is greater than in the past and is perhaps still increasing.

The answer to our question lies in the idea of the basic fault and in the observations that led me to the discovery of the 'new beginning'. My train of thought runs as follows: all of us have certain character traits or, expressed in modern terminology, compulsive patterns of object relationship. Some of these are the outcome of a conflict or complex in us; if the analyst with his interpretations can help his patient to solve these conflicts and complexes, the compulsive nature of these patterns will be reduced to a level flexible enough to permit adaptation to reality. In a number of cases in which, according to
my ideas, the patterns originate in a reaction to the basic fault, interpretations will have incomparably less power, since there is no conflict or complex in the strict sense to solve and in the area of the basic fault, words are not quite reliable tools anyhow.

In some cases in which words, that is associations followed by interpretations, do not seem to be able to induce or maintain the necessary changes, additional therapeutic agents should be considered. In my opinion, the most important of these is to help the patient to develop a primitive relationship in the analytic situation corresponding to his compulsive pattern and maintain it in undisturbed peace till he can discover the possibility of new forms of object relationship, experience them, and experiment with them. Since the basic fault, as long as it is active, determines the forms of object relationship available to any individual, a necessary task of the treatment is to inactivate the basic fault by creating conditions in which it can heal off. To achieve this, the patient must be allowed to regress either to the setting, that is, to the particular form of object relationship which caused the original deficiency state, or even to some stage before it. This is a precondition which must be fulfilled before the patient can give up, very tentatively at first, his compulsive pattern. Only after that can the patient ‘begin anew’, that is develop new patterns of object relationship to replace those given up. These new patterns will be less defensive and thus more flexible, offering him more possibility to adapt himself to reality under less tension and friction than hitherto.

The next and last question in this chapter will be: what can the analyst do to foster this process? The greater part of the answer will follow in the next chapter; here I would like to stress only three highly important negative aspects, that is, what the analyst must try to avoid doing. Our present fashion in technique – which recommends that, if at all possible, everything should be interpreted first as transference – tempts us to turn into mighty and knowledgeable objects for our patients, thus helping – or forcing – them to regress into an omniphilic world. In this world there are ample opportunities for dependence but very meager ones for making independent discoveries. I hope it will be generally agreed that the latter is at least as important therapeutically as the former. Conversely, this means that the analyst must not stick rigidly to one form of object relationship that he found useful in other cases or during the preceding phases of this treatment but must all the time be prepared to alternate with his patient between the omniphilic and the philobatic primitive worlds, and even go beyond them towards primary relationship. This can be done only if the analyst is capable of the differential diagnosis described above.

The other important negative aspect is that at times the analyst must do everything in his power not to become, or to behave as, a separate, sharply-contoured object. In other words, he must allow his patients to relate to, or exist with, him as if he were one of the primary substances. This means that he should be willing to carry the patient, not actively but like water carries the swimmer or the earth carries the walker, that is, to be there for the patient, to be used without too much resistance against being used. True, some resistance is not only permissible but essential. However, the analyst must be careful that his resistance should create only as much friction as is needed for progress but definitely not much more, otherwise progress may become too difficult owing to the resistance of the medium. Over and above all this, he must be there, must always be there, and must be indestructible – as are water and earth.

We discussed some of these aspects in Chapter 22, and we shall continue with them in those following.

A corollary to the previous negative aspect is our last one, also negative, that the analyst must avoid becoming, or even appearing in the eyes of his patient, ‘omnipotent’. This is one of the most difficult tasks in this period of the treatment. The regressed patient expects his analyst to know more, and to be more powerful; if nothing else, the analyst is expected to promise, either explicitly or by his behaviour, that he will help his patient out of the regression, or see the patient through it. Any such promise, even the slightest appearance of a tacit agreement towards it, will create very great difficulties, almost insurmountable obstacles, for the analytic work. Here too, the only thing that the analyst can do is to accept the role of a true primary substance, which is there, which cannot be destroyed, which eo ipso is there to carry the patient, which feels the patient’s importance and weight but still carries him, which is unconcerned about keeping up proper boundaries between the patient and itself, etc., but which is not an object in the true sense, is not concerned about its independent existence.

Several other authors tried to describe this sort of object
The regressed patient and his analyst

relationship or, more correctly, environment-patient relationship, using other terms. Anna Freud (war years) used 'the need-satisfying object'; Hartmann (1939) 'the average expectable environment'; Bion in a letter to the British Psycho-Analytical Society (1966) contrasted the 'container' with the 'contained'. The most versatile inventor of such terms seems to be Winnicott, who used (1941) the 'good enough environment', then talked about the 'medium' in which the patient can revolve like an engine in oil, then (1949) came his 'ordinary devoted mother', in 1956 the 'primary maternal preoccupation', then (1960) the 'holding function' of the mother, while in 1963 he borrowed the term 'facilitating environment' from the American literature and used it as part of the title of his last book (1967). Margaret Little called it the 'basic unit' (1961), while M. Khan proposed (1963) the 'protective shield' and R. Spitz 'mediator of the environment' (1965), while M. Mahler preferred (1952) 'extra-uterine matrix'. Any one of these terms is correct. Each describes one or the other aspect of this non-omnipotent relationship that I have in mind. Of course I am biased in favour of my term, among many others, for one reason that mine is more general and can accommodate all the others as its particular aspects.

If we accept these ideas, then the problem of whether or not to gratify a regressed patient’s cravings appears in a different light, so different that doubt arises whether we have not been struggling with a false problem which can never be solved because it is wrongly formulated. The real problem is not about gratifying or frustrating the regressed patient but about how the analyst’s response to the regression will influence the patient-analyst relationship and by it the further course of the treatment. If the analyst’s response, e.g. satisfying the patient’s expectations, creates an impression in the patient that his analyst is knowledgeable and capable, bordering on being omniscient and omnipotent, this response should be considered as risky and inadvisable; it is likely to increase the inequality between patient and analyst, which may lead to the creation of addiction-like states by exacerbating the patient’s basic fault.

On the other hand, if the satisfaction can be done in a fashion that does not increase the inequality but creates an object relationship according to the pattern of what I call primary love, then it should be seriously considered as a method of choice.

At this point I propose to digress briefly to discuss what I call the

Therapeutic regression, primary love, & basic fault

ocophilic bias of our modern technique and its consequences. Psychoanalytic technique—and theory—were so impressed by the intensity of ocophilic phenomena met in the analytic situation that they concentrated their interest on them, neglecting almost entirely the equally important primary and phallic relationships. Thus developed the theory of object-seeking, clinging, ‘attachment behaviour’, and ambivalent dependence. As I pointed out in Thrills and Regressions (1959), especially in Chapter 12, our modern technical procedure recommends that everything that happens or is produced by the patient in the analytic situation should be understood and interpreted first and foremost as a phenomenon of transference. Conversely this means that the principal frame of reference used for formulating practically every interpretation is a relationship between a highly important, omnipresent object, the analyst, and an unequal subject who at present apparently cannot feel, think, or experience anything unrelated to his analyst.

It is easy to see that this modern technique of interpreting transference first must lead to a picture of the world consisting of a rather insignificant subject confronted with mighty, knowledgeable, and omnipresent objects who have the power of expressing everything correctly in words, an impressive example of whom is the analyst. If one accepts this picture as a true and representative sample of the early stages of human development, one gets easily to the theory of ‘oral dependence’. The dependence is obvious, and the adjective ‘oral’ is speedily added to it under the influence of our theory of instincts, which has only this one word for the description of anything primitive or early. The fact that during the treatment conducted in this way nearly all transactions between patient and analyst happen through the medium of words, reinforces the ‘oral’ aspects, and analysts, patients, and our theory associate to it that interpretations—that is, words—may stand for ‘milk’ and the analyst for ‘the breast’.

A circular argument develops in this way; everything that happens in the analytic situation is understood and interpreted in this fashion, which in turn ‘teaches’ the patient—as described in Chapter 15—to express, and to some extent even to feel, all his pre-verbal experiences according to this language, thus convincing the analyst that both his theory and his interpretations were absolutely right. This is another instance of an event that has happened on many
The regressed patient and his analyst

occasions in practically every science, and especially in our psycho-
analysis, that parts of the truth have been used to repress the whole
truth. In our present instance the parts are: that 'oral' and 'dependent'
phenomena occur in every primitive human relationship. What is
repressed is that they are far from being able to explain the whole
picture; the only thing that happened was that by our present
technique their importance has been magnified out of proportion.

A very good proof for this view is Freud's example. As the study
of his case histories proves, he paid due attention to transference but
did not interpret it before anything else. In consequence, although he
was a very important object to his patients, his technique did not
force them to build up a picture of the world according to the
oppressive inequality between an oedipal subject and his all-
important object described above. As I have just mentioned, in the
indexes of the twenty-three volumes of the Standard Edition the
catchword 'dependence' occurs very rarely, while 'oral dependence'
does not occur at all.

To illustrate a number of problems raised in this chapter, may I
quote an episode from a long treatment. After an unsatisfactory
session on a Friday in which the patient accepted, rather reluctantly,
that no real contact could be established between himself and his
analyst because during the whole session the patient had to make his
analyst useless, he had great difficulties in leaving the room. Just
before the door was opened he said that he felt awful and asked for
an extra session, any time during the week-end, to help him to
recover.

The problem of course, is how to respond to this request which,
undoubtedly, is a request for gratification. I would add that this
patient occasionally got extra sessions during the week-end; these
always brought him very great satisfaction and, true to type, eased
the tension in him considerably each time; however, it was only
very rarely that in these extra sessions real analytical work was
possible.

Let us suppose that the request is interpreted as another 'craving'
of his, and refused on this account; even if the patient accepts this
interpretation, he will feel still more wretched for having unneces-
sarily pestered his kind and patient analyst, and his misery will get
worse. If the patient disagrees with the interpretation, he will experi-
ence the analyst as unkind and cruel, increasing thereby the tension

Therapeutic regression, primary love, & basic fault

in the therapy; it is doubtful whether the situation will be made
more tolerable if the analyst interprets it as a resistance or as a
transference of some aggressiveness and hatred from childhood.

On the other hand if he satisfies the request for an extra session,
no matter whether he interprets it as a repetition of some early
frustration prompted by, or leading to, greediness or envy, he turns
himself into an omnipotent object and forces his patient into an
oedipal relationship.

What I tried to do in this case was first to recognize and accept his
distress so that he should feel that I was with him, and then to admit
that I did not feel that an extra session granted by me would be
powerful enough to give him what he expected and perhaps even
needed at this moment; in addition this would make him small and
weak while his analyst would become great and powerful, which was
not desirable. For all these reasons the request was not agreed to. The
patient then departed dissatisfied.

I had two aims in mind when choosing my response. On the one
hand, I tried to prevent the development of undesirable relationships,
such as that between someone let down or frustrated by a harsh or
superior person in authority who knows better what is right, or that
between someone weak and in need of kind support, and a benign
and generous authority—all leading to a reinforcement of the
inequality between the subject and his mighty object. On the other
hand, I tried to establish a relationship in which neither of us would
be all-powerful, in which both of us admitted our limitations in the
hope that in this way a fruitful collaboration could be established
between two people who were not fundamentally different in import-
ance, weight, and power.

I have to add here that it was a very rare event indeed that my
patient rang me up. Perhaps not even as much as once per year in an
emergency. This time he telephoned me the same evening after 8
p.m. He could hardly speak on the telephone, dithered to and fro
for a long time, but at the end he was able to say that he had to ring
me up... to tell me that he was very near crying... nothing else... he
did not want anything from me, no extra session,... but he had
to ring me up, to let me know how he felt.

This episode shows how the analyst’s response turned a process
that started in the direction of a 'craving' for satisfaction—i.e. a
possibly malignant form—into a benign one—i.e. a regression for
The regressed patient and his analyst

recognition. It was done by the analyst avoiding even a semblance of being omniscient and over-powerful; on the other hand he demonstrated his willingness to accept the role of a primary object whose chief function is recognizing, and being with, his patient.

The immediate effect of this incident was a considerable lessening of the tension, the patient had a comparatively good week-end, and for quite some time afterwards he was capable of contact and cooperation. I would even say that it initiated—or reinforced—a change for a better atmosphere in the analytic situation, in which it was possible to make some considerable progress.