The Basic Fault

Therapeutic Aspects of Regression

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Chapter 14

Regression and the child in the patient

Analysts, as a rule, tolerate communications in the therapeutic situation in addition to those expressed in words. This 'tolerant' policy leads to certain consequences. Perhaps the most important of them is that it opens the door to acting-out, which is tantamount to regression, for words are always a more adult form of communication than action or even gesture.

In a way, the process of maturation and civilization amounts to moving less and less physical mass, i.e. using less and less muscular energy, for the expression of the same idea, effect, or message. That means that as fewer and fewer muscles are involved, the movements become finer and subtler. Of all the skeletal muscles perhaps the speech muscles have the smallest mass and are the subtlest and finest; consequently, moving them uses less energy than moving any other. The maturation process, however, does not stop here. The child, or the primitive, first substitutes shouting or screaming in place of acting, then he learns to shout and scream less, i.e. to express the same intensity of emotion by using smaller amounts of physical mass and muscular energy. The reward for this restraint and discipline is an ever increasing subtlety and richness of expression involving the conscious and preconscious mental life. It is thinkable that it may extend beyond it into the unconscious; this would be another instance of what Freud called the education of the instincts.

It is in the nature of the analytical situation to reverse, to some extent, these processes of maturation and civilization. Instead of subtly adumbrating or implying, the patient learns to state explicitly and often with primitive intensity what he thinks and feels; soon he realizes that detached factual descriptions are not sufficient, their concomitant emotions will have to be expressed as well. He then proceeds to vary the intensity and pitch of his voice, to use gestures or movements; he may even be carried away by his emotions, and so he comes to act-out in the transference, or in the analytical situation.

All this inevitably amounts to giving way to a regressive trend involving both the patient and his analyst. What will happen now depends on the analyst's responses. Of course, every analyst will try to understand what the patient tries to convey to him by the acting-out; but in order to influence the acting-out the analyst must communicate – i.e. express – his understanding of it in some way. However, his individual way of expressing his understanding or, as I like to call it, his habitual responses to the patient's 'acting-out', 'behaving', or 'repeating', may vary greatly, and all such variations, whether used consistently or not, will influence considerably the 'atmosphere' in the analyst's consulting room.

The first analyst who described the atmosphere created by his consistent 'responses' was, of course, Freud, who likened it to the reflection by a well-polished mirror. This means – if taken literally – that the analyst does not bring any alien material into the analytic work, he only *reflects* without distortion what originates from the patient. This can happen only – though this has never been explicitly stated – if the material produced by the patient consists almost exclusively of words and, *a fortiori*, the analyst's contributions to the developing situation also consist exclusively of words. All these words coming from the patient as well as from his analyst are used and mutually understood in the conventional adult way. In fact, in the case histories published by Freud, I could not find an interpretation of any non-verbal material produced by a patient, though as early as in the *Studies on Hysteria* (1895) he recorded observations of non-verbal phenomena. Knowing how mercilessly accurate Freud's reports about his clinical work are, this self-imposed restriction appears self-evident. A mirror reflects an image but does not change its nature; words, therefore, may be reflected by words, but the translation of non-verbal material into words would go beyond the function of mirror-like analytic work.

Gradually we have learned to understand and to use not only the verbal material produced by our patients, but also what I call the 'atmosphere', created partly by words, partly by the patient's manner of using them, and partly by all that is called 'acting-out', 'behaving', or 'repetition' in the analytic situation. This latter group, as I have just pointed out, always has an aspect of regression.

Clinically this means that phenomena suggesting regression will be observed from time to time during any analytic treatment. There

are, however, widely differing views among analysts about the frequency, the meaning, and the importance of these phenomena. Views vary also about the extent to which these phenomena are caused by the patient, that is, by his personality, by the nature and severity of his illness, or by the analyst's individual technique. In my opinion, both analyst and patient have their share in it but it is not easy to disentangle how much is due to whom. Any description singling out exclusively one partner's share will probably be faulty from the start. But even if one is aware of this pitfall, it must be expected that every description will be coloured by the personal bias of its author, in particular by his ordinary experiences which, at any rate partly, are determined by his individual technique. My description will be no exception to this rule.

Of course, the contributions of neither partner are fully verbalized during the treatment – or, for that matter, in scientific discussions – though the scales are definitely weighted. On the whole, it is the patient who is gradually made to express his non-verbal contributions – among them his regressive propensities – in words, thus 'changing his repetition into recollection'; whereas the analyst is, as a rule, under no such pressure. His professional behaviour, i.e. the details of his technique, are felt to be so well standardized that they appear to him 'natural', sensible and scientifically justified, so much so that in 'normal', smoothly proceeding, cases he will not feel any need to change his 'repetition into recollection' by expressing his habitual behaviour in the therapeutic situation in words, so that it may be subjected to a searching scrutiny. In many respects this policy is sensible and realistic – if for no other reasons than those of mental economy. The analyst can further reassure himself that his behaviour had passed a searching scrutiny of this kind in the past, during his training. It is in this way that analysts arrive at the idea of 'classical' or 'proper' technique – as the case may be.

Let us follow, though only for a short while, this example and start with the patients' contributions. Patients differ considerably as regards regression. On the whole, one may differentiate two extreme types among them, of course with a number of intermediate grades. With one extreme type quite satisfactory therapeutic results can be achieved without much regression beyond the Oedipal level. With the other, for quite a while, hardly any real, stable, results can be obtained, merely what is called short-lived transference improvements;

real therapeutic results occur only after a period of regression, which may be short or long but is always more primitive in nature than the well-known phenomena belonging to the Oedipal level.[1]

Let us turn now to the analyst's responses which, as just discussed, are an important part of his contribution to the developing 'atmosphere'. Good examples of possible variations are the analyst's responses to a patient's request to prolong the analytic session. The

[1] One possible theoretical explanation of these differences uses the idea of trauma. According to it the individual had developed more or less normally up to the point when he was struck by a trauma. From that point on his further development has been fundamentally influenced by the method he developed at the time for coping with the effects of that particular trauma – his basic fault. The trauma itself, of course, is not necessarily a single event; on the contrary, usually it amounts to a situation of some duration caused by a painful misunderstanding – lack of 'fit' – between the individual and his environment. As a rule, the individual is a child and his environment consists of the world of his adults.

True, despite the general lack of 'fit', in some cases some adult, or even adults, may be on the child's side, but much more often than not the immature and weak individual has to cope on his own with the traumatic situation; either no help is available to him, or only help of a kind that is hardly more than a continuation of the misunderstanding, and is thus useless to him.

Thus it comes about that the individual is made to adopt his own method for coping with the trauma, a method hit upon in his despair or thrown at him by some un-understanding adult who may be a well-wisher, or just indifferent, negligent, or even careless or hostile. As I have just said, the individual's further development will then be either prescribed or, at any rate limited, by this method which, though helpful in certain respects, is invariably costly and, above all, alien. Still, it will be incorporated in his ego structure – as his basic fault – and anything beyond or contrary to these methods will strike him as a frightening and more or less impossible proposition.

The task of analytic treatment consists then in dealing with the fears obstructing the way to re-adaptation – called 'fixations' – and of enabling the patient to broaden his potentialities and develop new methods for coping with his difficulties. The result of this undertaking, of course, depends also at what point the trauma struck the individual and how far the method chosen at the time is compatible with the development of any form of 'genital love'. In some cases of treatment it is apparently necessary to go back to the pre-traumatic period, to enable the patient to relive the trauma itself in order that he may mobilize his 'fixated' libido and find new possibilities for dealing with the problems involved. If the trauma happened at a comparatively late stage of his development, the point to which the treatment has to go back will already be in the area of the Oedipal level, and thus no regression beyond this will be needed, and possibly still less observable in the analytic situation. On the other hand, if the trauma struck the patient at a point beyond the Oedipal area, it is likely that considerable regression must take place and will be observed.

traditional length is fifty minutes[1] and as a rule the analyst has five to ten minutes free before subsequent sessions. In principle, shall one, or shall one not, agree to a patient's request to be allowed to stay occasionally five or ten minutes longer? Or shall one compensate him if he arrived five to ten minutes late? Disregarding the fact that the analyst's flexibility is also limited by external circumstances (the next patient may already be waiting; on the other hand, the analyst may happen to have a free session following his patient's and the patient for some reason or other has, or has not, got a knowledge of this fact, etc.), should he agree to an extension of the session at all and, if so, what criteria should he use to determine whether an extension is advisable or not?

A still more difficult form of the same problem arises when the request is for an extra session during the week-end, after a day's work, or even during the analyst's holiday. I think it is irrefutable that, in whatever way he responds, it will be not only the patient but also the analyst who contributed to creating an 'atmosphere' in the analytic treatment. Anna Freud's often-quoted patient who was allowed to ring up the analyst any time during the day or even the week-end is a convincing proof that acceptance and gratification of some regressive tendencies, or of acting-out, is not altogether incompatible with 'classical' technique; in other words, is not an irreversible parameter.

The instances just described are rather gross samples of the analyst's responses to a patient's regressed acting out; I chose them since, because of their simple structure, they could be easily discussed. Although it is more difficult to demonstrate, it is certain that there are innumerable ways in which the analyst may respond to his patient's subtle forms of regression. His response may amount to indifference, disapproval, or perhaps only to some slight sign of annoyance; he may tolerate the acting out, but follow it immediately with a correct and timely interpretation which, in turn, will take the patient some steps further towards learning the analyst's language and will inhibit further acting-out; he may sympathetically permit it as a kind of safety valve; or he may take it in his stride, as a matter of course, feeling no more, or for that matter no less, need for interpretation, i.e. for interfering with the acting out, than with any other

[1] When I started practising psychoanalysis, in the early twenties, it used to be fifty-five minutes.

form of communication, say, verbal associations. Evidently it is only in this last case that acting-out and verbal associations are equally accepted as communications addressed to the therapist.

The analyst may accept his patient's needs to regress only as understandable communications, as fantasies, which in all other respects are completely unrealistic; consequently the analyst's response – explicit or implicit – will mean that any gratification of such needs would be incompatible with the analytic situation. A somewhat different way would be to accept them as justifiable within the analytic situation. And lastly, it is also possible not only to accept some of these needs as fully justified, but also to gratify them – as far as the gratification is compatible with the analytic situation. It was exactly this that happened in Anna Freud's case, quoted above.

Of course, all these responses contribute – each in its way – to the developing 'atmosphere' of the treatment. Some responses open widely the door to regression, others offer only a narrow opening, and still others try to prevent it. Thus regression during analytic treatment depends not only on the patient but also on his analyst. In Chapters 16–18 we shall return to examine some of the 'standardized' responses and their consequences in detail. But before doing so I will describe the inevitable consequences of regression which is allowed to go beyond the Oedipal level.

As we have just observed, under the influence of the psychoanalytic setting all patients without exception regress to a point; that is, they become childish and experience intense primitive emotions in relation to the analyst; all this, of course, is a constant part of what is generally called transference.

The impact of these highly charged emotions brings about a curious inequality in the relationship between analyst and patient. The analyst is felt as a powerful, vitally important person, but only so far as he is able or willing to gratify, or to frustrate, his patient's expectations, hopes, desires, and needs; beyond this sphere the analyst, as an everyday, real person, hardly exists. Of course, the patient has all sorts of fantasies about his analyst but these, as a rule, have more to do with the patient's inner world than with the analyst's real life and real personality. Although in comparison with the analyst the patient usually experiences himself as weak and far less important, it is only he (the patient) who matters, and matters enormously; it is exclusively his wishes, urges, and needs

that must be attended to, and it is his interests that must be the focus of attention all the time.

This pattern is general; though there are no exceptions to it, its intensity and duration vary with individual patients. Some patients do not go beyond a certain point; the therapeutic processes initiated in this way are effective enough to bring about sufficient readjustment; and after a time the patient spontaneously emerges from this primitive two-person relationship and is cured. With other patients, however, additional processes take place over and above those just described.

In Part I, I surveyed at some length these processes as they may be observed by the therapist. Here I shall enumerate only the most important of these observations: words lose their reliability as agreed means of communication between patient and analyst; interpretations, in particular, tend to be experienced by the patient either as signs of hostility and aggressiveness, or of affection. Patients begin to know too much about their analysts; it is fairly common that they are more aware of their analyst's moods than of their own; in parallel their interest becomes apparently more and more detached from their own problems and sufferings, which originally prompted them to seek analytic help, and gets centred more and more on divining the analyst's 'real motives' for saying this, for behaving that way, or having a particular 'mood'. All this absorbs a considerable amount of libido and this is perhaps the reason why patients in this state apparently lose a good deal of their drive to get better, of their wish, and even their ability, to change. Parallel with this, their expectations from the analyst grow out of proportion to anything realistic, both in a positive sense, in the form of sympathy, understanding, attention, small gifts, and other signs of affection, and in a negative sense, in the form of fierce attacks, merciless retaliation, ice-cold indifference, and extreme cruelty. To condense this situation into one sentence, one might say that the importance of the past is well-nigh lost for the patient; only the analytic present matters.

In customary analytic terms all this would be described as an exacerbation of the transference neurosis or transference love which has taken full command of the therapeutic situation and, in fact, has become so intense that it is now impervious to ordinary interpretations. Some analysts think that this development is caused by the patient's paranoid, persecutory fantasies invading the

transference. In my opinion all these descriptions are too weak, and so miss the real issue (1958).

It is well known that even the most skilled and experienced analysts among us at times have difficulties with some of our patients, and even occasional failures. However unpleasant, it must be accepted that there are no exceptions to this rule. My contention is that the great majority of difficulties and failures arise in the treatment of patients who exhibit the signs just described. These patients are usually characterized as 'deeply disturbed', 'profoundly split', 'seriously schizoid or paranoid', 'suffering from a deep narcissistic wound', 'having a much too weak or immature ego', and so on; all these descriptions imply that with these patients the root of their trouble goes further or deeper than the Oedipus complex, our usual concern with the average patient.

In order to get a better understanding of some of the difficulties encountered in our therapeutic work with this class of patient, I proposed in Part I to consider the human mind – or perhaps only that part of it which is called the ego – as consisting of three areas, that of the Oedipus complex, that of the basic fault and that of creation. Each area is characterized by a specific form of the mental force operating in it, and lastly, by a specific level of the mental processes. To recapitulate briefly:

In the area of the Oedipus complex the characteristic structure is a triangular relationship, consisting of the subject and two objects; the characteristic force is that originating from a conflict, and the level of mental processes is that which corresponds to, and can adequately be expressed by, conventional, adult language.

In the area of the basic fault the prevalent structure is an exclusively two-person relationship, more primitive than those obtaining between adults. The form of mental force is not that of a conflict; what the form is will be discussed later in Parts IV and V. However, already here I can mention that under certain conditions the force operating at this level creates addiction-like states, and is then habitually described in our literature as greed. The level of mental processes, in particular as they appear in the therapeutic situation, is denoted by such terms as 'pre-Oedipal', 'pre-genital', 'pre-verbal', etc. In Chapter 4, I discussed in detail the reasons why I believe these terms to be misleading and why I proposed to call it the level of the basic fault.

And lastly we have the the area of creation, characterized by the absence of any outside object. As our analytical method is based on transference, i.e. inseparably linked to the presence of at least one outside object in addition to the subject, we have no direct access to the study either of the level of mental processes in this area or of the form of forces operating in it. Nevertheless, processes happening in this area are of great technical importance to us, as instanced – among many other examples – by the problems created by a silent patient.

Thus one may expect to encounter three different sets of therapeutic processes in the mind, and possibly expect also that analysts may need three different sets of technical measures, each directed so that it should influence the corresponding area of the mind. Moreover, as the analytic situation is an essentially two-person relationship, with many qualities that are definitely more primitive than those belonging to the Oedipal level, one would also expect that our theoretical knowledge relating to the area of the basic fault, and our technical methods for dealing with the problems encountered in it, would be in a far better developed and far more securely founded state than anything pertaining to the two other areas.

Of course, exactly the opposite is the case. Almost the whole of our theory pertains to mental structures and processes belonging to the Oedipal level, and what is called the 'classical' analytic technique – doubtless the best founded variety of all analytic techniques – deals almost exclusively with problems that have a dynamic structure activated by some conflict, or conflicts, and can be expressed without much difficulty in conventional language, i.e. with problems belonging to the Oedipal area.

To demonstrate the nature of the difference between technical problems arising from the Oedipal area and those arising from the area of the basic fault, let us review the phenomena of regression from yet another angle. It is one of the earliest clinical observations that at some point or other during analytic treatment patients cease to be willing to cooperate. This may take the form of a refusal to move, to change, of an apparently complete inability to accept any adverse external condition or to bear any increase of tension. If the period of non-cooperativeness is limited, it is said to be due to a passing resistance or to 'splitting', but if it is lasting, to prevalence of schizoid-paranoid mechanisms. Another class of interpretation

attributes these states to an insoluble resentment against the mother, and her later representatives, for not giving the patient the affection, sympathy, and understanding that he should have had.

Though it has always been accepted that there is an uncooperative part in every patient, there has been little discussion on what decides how much or how little of a particular patient cooperates in a particular analytic situation at a given period. In severe cases of regression the patient seems to be unable to apprehend what is expected from him, e.g. compliance with our 'fundamental rule'; at such times it is practically useless to try to remind him of his original complaints that prompted him to seek analytic help since he has become exclusively preoccupied with his relationship to his analyst, the gratifications and frustrations that he may expect from it; all sense for continuing with the analytic work seems to have been lost. When it is realized that this kind of transference, absorbing nearly all the libido of the patient, has the structure of an exclusively two-person relationship – in contrast to the 'normal' Oedipal transference, which is definitely triangular – one recognizes it as yet another diagnostic sign that the patient has reached the area of the basic fault.

This leads us directly to our main topic, namely, how to enable an uncooperative part of an individual to cooperate, that is, to receive analytic help. What I mean here is something different from resolving resistances, i.e. conflicts, at the Oedipal level, or from undoing a 'split' – it is something more akin to stimulating, or perhaps even to creating, a new willingness in the patient to accept reality and to live in it, a kind of reduction of his resentment, lifelessness, etc., which appear in his transference neurosis as obstinacy, awkwardness, stupidity, hypercriticism, touchiness, greed, extreme dependence, and so on.

It was in order to explain this utterly different clinical impression that I assumed that there was something to be called the basic fault, which is not a complex, nor a conflict, nor a split, but is a fault in the basic structure of the personality, something akin to a defect or a scar. Most patients, of course, cannot tell us what causes their resentment, lifelessness, dependence, i.e. what the fault or defect in them is. Some, however, are capable of expressing it by its opposite, i.e. by fantasies about a perfect partner, or of perfect harmony with their whole environment, perfect untroubled happiness, perfect

contentment with themselves and with their world, and so on. In the most frequent form, however, the patient repeats over and over again that he has been let down, that nothing in the world can ever be worth while unless something that was taken away or withheld from him – usually something unattainable in the present – is restored to him, and in severe cases even says that life is not worth living without his loss being made fully good, and he behaves as if this were really true.

I wish to illustrate this kind of atmosphere by two dreams experienced by a patient during the same night.[1] (1) She was walking in a wood; suddenly a large flesh-coloured bird swooped down, hit her violently, and made a gash in her forehead. Patient was stunned and fell to the ground unconscious. The terrible thing was that the bird never looked back; it was quite unconcerned about what it had done. (2) Patient was then in a room with a number of friends who were playing games which she used to share with them. Nobody took any notice of her. The terrible thing was that she was alone for ever because she would never be able to get over the thought that the bird did not look round. It should be added that many dreams of this pattern were brought during a particular period.

In another pattern the patient repeats endlessly that he knows he ought to cooperate, but he must get better or even quite well before he can do anything about it. At the same time he is fully aware of the reality situation, namely, that improvement is impossible without his cooperation; this insight, however, only exacerbates the despair in him. This vicious circle – in the patient's sincere conviction – can be broken only if either something that has gone wrong is replaced in him, or if he can get hold of something in him which he had had at one time but has since lost.

Sophisticated patients – and analysts – may express this something irretrievably lost or gone wrong as the penis or the breast, usually felt to possess magical qualities, and speak of penis or breast envy, of castration fear; Jones's (1927) concept of aphanisis belongs here, as do Melanie Klein's (1957) ideas about inborn jealousy and envy; however, in nearly all cases all this is coupled with an unquenchable and incontestable feeling that, if the loss cannot be made good, the patient himself will remain no good and had better go mad or even die.

[1] I am indebted to my wife for this clinical material.

All the phenomena of regression, as observed in the analytical situation, strike one irresistibly as primitive, reminiscent of early childish behaviour; a strong argument for the thesis that any neurosis or psychosis possesses necessarily some infantile features and that any psychotherapist must always be aware that he will have to deal – in one way or another – with 'the child in his patient'.

We know that there are fairly great difficulties when 'the child in our patient' is of the age of the Oedipus conflict. But the gulf separating us adults from 'the child in our patient' of the age of the basic fault – the 'infant' in the true sense of the word, i.e. one who cannot speak, at any rate, the language of adults – is considerably deeper and wider than anything encountered at the Oedipal level where, after all, everyone is using agreed conventional language. In spite of this increased difficulty, the gulf separating patient and analyst must be bridged if the therapeutic work is to continue. It must be realized, however, that the patient – that is, 'the child in the patient' of the age of the basic fault – is unable to bridge the gulf on his own. The great technical question is, how to bridge this gulf? Which part of this task should be undertaken by the analyst and which should be left to the patient?

To avoid a possible misunderstanding, I wish to emphasize that in what follows I shall discuss the technical problems encountered with patients regressed to the level of the basic fault. It is probable that this is only one type of the so-called 'deep' regressions. I think that a closer analytic study of truly schizophrenic patients – but not that of 'schizoid characters' – may possibly reveal characteristics which will differentiate 'schizophrenic' regression from the form with which we are concerned here.

Analysts, of course, have long recognized these two technical problems – the task of bridging the gulf separating us adults from 'the child in the patient' and overcoming the patient's inability to accept reality and to cooperate in the therapeutic work – and have developed various methods for coping with them. What is not emphasized sufficiently in the literature on this topic is that there are several hazards that threaten a therapist who is trying to bridge the gulf separating him from a regressed patient, especially when the regression has reached the area of the basic fault; and that all the hazards are caused by his responses to phenomena belonging to this area.

My plan is to discuss in Chapter 15 the general influence of language on the analytical situation and then to devote Chapters 16–18 to a description of some of the 'standardized' responses to a regressed patient, and their consequences. This will be followed, in Parts IV and V, by a discussion of my clinical experiences with regressed patients and of the techniques that I have found useful in these situations.

however, always the establishment of a new relationship between the patient and some part of his world which has hitherto been barred by the gulf created by his basic fault, and, in consequence, one step towards a better integration of his ego.

As I have just said, what I have compressed in this Part is not the whole story either. I can even point out some of the missing chapters. First, I have not said anything about the function of repetition, of acting-out, in analytic therapy or, in other terms, I have not defined when, how far, and under what conditions, repetition may become a therapeutic agent. Another chapter would deal with the ways potentially open to a patient to change his internal world which largely determines his relationship to external objects. A parallel chapter would discuss the technical means available to us analysts for helping our patients to achieve this change. And lastly, a very important chapter indeed would deal with the functions of interpretations. I mean here the classical interpretations, in the periods *between* successive regressions. The technical problem I have in mind is how to integrate the two important tasks that have to be achieved by the same interpretations. The one is the creation and maintenance of an atmosphere in which certain therapeutically important events may take place; and the second is to enable the patient to realize what his own and what his analyst's contributions have been to the creation of this atmosphere; how these two determined each other on the one hand, and the final outcome on the other. I hope it has become clear that whatever atmosphere is created, it leads to certain interpretations and excludes others; and on the other hand, certain interpretations create a particular atmosphere, while avoiding these interpretations will create one that is totally different.

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