To the Graduate Council:

I am submitting herewith a dissertation written by Arnold Donald Trasente entitled "The Therapist's Experience of the Patient's Regression in Therapy." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

Leonard Handler, Major Professor

We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

Vice Provost
and Dean of the Graduate School

THE THERAPIST'S EXPERIENCE OF THE PATIENT'S REGRESSION IN THERAPY

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Arnold Donald Trasente

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ABSTRACT

The purpose of this study was to describe and analyze therapists' experiences of patients who entered benign and malignant regressions in therapy. Eight experienced therapists were interviewed to obtain their descriptions, determinants, and explanations of the phenomenon. A phenomenological procedure organized the interview data into 27 content categories. These contents were analyzed, to identify all meaningful elements and themes, and presented in a detailed summary.

Three underlying themes were then identified which integrated all the findings. The first theme, attachment versus detachment, was defined as the presence or absence, respectively, of a solid bond, trust, and alliance between the patient and therapist. The second theme, integration versus disintegration, was defined, respectively, as the maintenance or dissolution of self and ego structures, functions, and boundaries in the patient and therapist. These themes were tied to regression as a process in therapy. The third theme, primary and secondary process, involves two coexisting modes of experience and functioning which define regression as a fundamental psychological phenomenon.

Regression appears to be a natural, unitary phenomenon involving the primary processes becoming figural relative to the secondary processes. Along a continuum of regressive phenomena, benign regressions are characterized by patients maintaining an attachment to the therapist, structural and functional integration, and the operation of secondary process while primary process becomes figural. At the

other end of this continuum, malignant regressions reflect a detachment from the therapist, a structural and functional disintegration, and the loss of secondary process operations when primary process is figural.

The discussion detailed an integrated model of regression in therapy focusing on structural and relational factors which establish regressive potentials. In this model primary process was described as the patient's direct "lived experience" and secondary process the detached "observed experience." Emphasis was placed on the need to directly rework constantly emerging past, primary process interpersonal experiences, through the therapeutic relationship. The therapist's reworking or recapitulation, respectively, of earlier object failures were considered precipitants for benign versus malignant regressions. Therapists were urged to attend to the patient's continual regressions and to view the phenomenon positively as an essential therapeutic tool.

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CHAPTER I

INTRODUCTION

The purpose of this study is to describe an historically ambiguous and often misunderstood phenomenon, regression in psychotherapy. As both a clinical and developmental phenomenon, regression is often defined as the opposite of progression, as "a retreating; a moving backward" (Chaplin, 1975, p. 450). Relative to progression, regression has traditionally been portrayed as the "black sheep" of the pair.

The question arises, if progression is necessary for healthy development, can the opposite process be beneficial? The answer appears to be that sometimes it is and sometimes it is not (A. Freud, 1963). Consequently, this research examines both sides of regression, the "good" and the "bad," from the perspective of the therapist's experiences of the patient.

Two Preexisting Categories: Benign and Malignant Regression

Balint (1968) has identified two types of regression in psychotherapy. He describes benign regression as an ally of the treatment process, while malignant regression is described as a pathological resistance to treatment. Other clinicians have also described two types of regression, generally along the same lines as Balint (Alexander, 1956; Calder, 1958; Frijling-Schreuder, 1966; Giovacchini, 1984; Guntrip, 1969; Meissner, 1981; Winnicott, 1975).

Thus the previous research reflects an existing categorization of regressive phenomena in psychotherapy. Within the literature, however,

the specific nature of either type of regression can vary notably between respective observers, blurring distinctions and contributing to the ambiguity of the phenomenon.

The present research accepts the two categories of regression and uses them as the basis for a formal analysis of the phenomenon. It is not assumed, however, that these categories necessarily define and identify all regressive phenomena in the therapeutic process.

Given the ambiguous nature of regression, which is not readily quantifiable, a phenomenological methodology was used in order to describe and delineate the two types of regression. Thus, the methodology represents a second order phenomenological analysis which builds on existing research.

Definitions

The study deals with regressions which emerge within the process of individual outpatient psychotherapy. The research is not directed at clinical work with patients who enter therapy already manifesting a severe degree of functional regression. The focus is on regressions, relative to the level of functioning at the beginning of treatment, which emerge within or across therapy sessions within the context of the treatment process.

At this point, a general working definition of regression can be formally stated drawing on the work of Menninger and Holzman (1973). In defining the concept, they state:

> What we call regression in the psychoanalytic treatment situation refers to a very considerable retrograde process of personality functioning. There is a regression to earlier and

> more primitive ways of feeling, experiencing, and behaving. There is a constriction in the field of attention, a preoccupation with the self, and a simplification or reduction in the structural complexity of psychological functioning. Primary processes emerge and secondary processes diminish in importance (p. 47).

Drawing on the literature brief working definitions of the two types of regression can also be presented. Simply stated, benign regression is an ally of the treatment process and a clinical tool employed by therapists to bring about therapeutic changes in patients. Malignant regression represents a potential barrier to therapeutic change because it can obstruct or terminate the therapeutic process.

Goals of the Research

The goal of the research is to clearly describe, differentiate, and understand therapists' experiences of benign and malignant regression. The research also explores an hypothesis, presented at the end of the Literature Review, regarding possible factors contributing to the emergence of either type of regression. Given the nature of the research, however, the hypothesis cannot be directly tested and is therefore evaluated in the Discussion rather than the Results section.

While various therapists throughout the literature have provided case examples of their experiences with regression, there are no references to formal research. Extensive reviews of the topic in the form of panel discussions or workshops have unfortunately lead to more questions than answers since little analysis, critical evaluation, or integration was attempted. Consequently, our understanding of regression remains fragmented and ambiguous since an overview is

lacking. The seemingly elusive nature of the phenomenon has contributed to this confusion and the absence of any systematic, formal research.

Therefore, the specific goals outlined above are embedded within the more general goal of establishing a concrete means of identifying, describing, and understanding regression. Here the goal is to demonstrate that a formal, empirical evaluation can be performed on a rather elusive phenomenon.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

In the literature on regression in psychotherapy it appears that most authors subscribe to either an object relations or more classical psychoanalytic theory. Since the two orientations result in somewhat divergent perspectives on regressive phenomena in the literature they are presented separately in this review.

The Role of the Literature Review

The goal of a phenomenological study is to let the phenomenon speak for itself in order to capture its unique qualities in its most natural form. Therefore, it can be argued that a review of the literature is unnecessary since the phenomenon can be studied independently of previous research or hypotheses. This research does not take that position.

The Literature Review is overtly necessary in validating the two categories of regression which are the focus of this study. However, the literature also plays a more fundamental role in providing a basis and direction for the current study.

Many of the therapists who have examined regression have used an informal and intuitive phenomenological approach to their experiences with patients. Thus, the current research reflects a formal extension of this methodology. Due to its unsystematic and often contradictory

nature the literature speaks to the need for a formal analysis and integration of regressive phenomena. This study attempts to meet that need so that an explicit framework is available for understanding the phenomenon and for integrating the literature.

Psychoanalytic Theory: Benign and Malignant Regression

The review and discussion of the literature in this section presents the development of the concept of regression within psychoanalytic theory. The literature reflects a process of moving towards viewing the phenomenon in both structural and relational terms. In this process there is a shift toward more direct use of benign regression in analysis with an increasing focus on the effects of the therapeutic relationship on the patient's regression. Within the review, attention is given to developments in both the theory and the technique of regression in psychoanalysis.

Freud and Breuer: The Initial Formulation of Regression

The concept of a regression in psychic functioning was first recognized by Breuer (1893/1955), in Studies on Hysteria, in relation to what he identified as the "retrogressive" (p. 189) and consequently psychopathological processes involved in an hallucination. Thus, the concept was initially cast in a pejorative light.

Freud's (1900/1965) first written reference to regression was in 1900 in The Interpretation of Dreams, where it was used to explain the hallucinatory nature of dreams, in a manner similar to Breuer's use of the concept with hallucinations, and represented a minor mechanism "of

defence against incompatible ideas" (Balint, 1968, p. 119). While applying it to dreams, Freud (1900/1965) states that "... regression plays a no less important part in the theory of the formation of neurotic symptoms" (Freud, 1900/1965, p. 587). Thus Freud first identified regression as a defense mechanism and a factor in the pathogenesis of neurotic symptoms.

Freud (1900/1965) distinguishes three types of regression: topographical, temporal, and formal. Topographical regression refers to a reversal within the psychic system from conscious to preconscious to unconscious levels. Temporal regression involves a return by the psychic apparatus to more primitive or earlier psychical states and levels of functioning, with the emergence of earlier psychic content and modes of behavior. Freud saw temporal regression as a regression in time where the libido, object relations, and ego achievements return to more primitive levels.

Formal regression refers to the replacing of more mature and generally used psychic functions and apparatus with more primitive modes resulting in less mature modes of functioning. For Freud (1900/1965), the deeper the regression, temporally, and the more complete the regression, formally, the more pathological it was. In general, he defines regression as "a reversion from a higher to a lower stage of development" (1920/1953, p. 351).

Freud (1912a/1963) also outlines how regression is expressed in the transference as resistance. He indicated that the "regressed form of transference was the most potent type of resistance" (Balint, 1968,

p. 121) which repeatedly presents itself, requiring continual attention.

Freud (1920/1953) also links regression with the process of fixation and subsequently to the repetition compulsion. In addressing fixation and regression in the course of psychosexual development, Freud (1920/1953) states:

> ... those portions [of the developing psychic apparatus i.e. ego] which have proceeded further may easily revert in a backward direction to these earlier stages. The impulse will find occasion to regress in this way when the exercise of its function in a later and more developed form meets with powerful external obstacles, which thus prevent it from attaining the goal of satisfaction. It is a short step to assume that fixation and regression are not independent of each other; the stronger the fixations in the path of development the more easily will the function yield before the external obstacles, by regressing on to those fixations ... (p. 350).

In reviewing Freud's development of the concept, it appears that he took a rather cautious approach and a distrustful view of regression (Balint, 1968; Bienenfeld, 1985). Most of his attention was focused on the potentially pathological aspects of the phenomenon, as a defense, as a resistance, and as an agent in the development of psychopathology. Patients were seen as independently manifesting the phenomenon in response to analytic efforts. Techniques were therefore directed at reducing the regression's potentially anti-therapeutic effects, with little consideration of the therapeutic application of the phenomenon.

Freud (1914/1957) made one reference to the potentially benign aspects of regression in the Dora case, where the therapeutic success hinged on following her back to the earliest childhood experiences before other work could be done. Freud states:

> In the analysis of the patient I named 'Dora' [1905e], carried out in 1899, I had knowledge of the scene which occasioned the outbreak of the current illness. I tried innumerable times to submit this experience to analysis, but even direct demands always failed to produce from her anything more than the same meagre and incomplete description of it. Not until a long detour, leading back over her earliest childhood, had been made, did a dream present itself which on analysis brought to her mind the hitherto forgotten details of this scene, so that a comprehension and a solution of the current conflict became possible (p. 10).

Freud (1914/1957) indicated that over the course of the analysis Dora's associations regressed to early childhood experiences which were useful since a focus on the present alone was unable to successfully work through early childhood conflicts. He subsequently stated how inappropriate it was to neglect the therapeutic use of regression in psychoanalysis. While acknowledging the two types of regression, Freud never formally addressed the therapeutic uses of regression again, leaving this to others.

Franz Alexander: Regression as Resistance or Therapeutic Ally

The work of Alexander (1956) is significant since he elaborates and extends Freud's position on regression to include its therapeutic potentials. For Alexander the malignant form reflects a regression to fixation, which emerges early in the positive transference and involves the patient's infantile wishes for oral dependence and gratification as well as an attempt to avoid dealing with the central oedipal conflicts.

In general, though not always, Alexander believes regressions to preoedipal levels are defensive in avoiding oedipal conflicts. Hence, the level to which the patient regresses should not be equated with the source of their pathology.

In order for regression to be therapeutic, Alexander states that it must involve a return to an unresolved traumatic situation, in order to attempt a belated mastery without fear of ego disintegration. This form of regression is not directed at obtaining gratification, and can therefore be an ally of the treatment. Alexander (1956) states:

> Freud's explanation for this type of phenomena was that the ego's fundamental task is to maintain a stable equilibrium within the mental apparatus; if it fails to fulfil this task, it retains a tendency to achieve a belated mastery. It again and again returns to the traumatic event in order to resolve the tension (p. 195).

Alexander, like Freud, remained cautious about the use of any regression in analysis since benign forms can easily become malignant, suggesting the fine line separating the two types of regression. Significant in Alexander's formulation, however, is his identification of the potential to directly rework earlier failure experiences through regression, endowing it with important therapeutic application.

Kris and Hartmann: Regression as an Adaptive Function

The work of Ernst Kris (1975) and Heinz Hartmann (1964) is significant in its primary focus on the adaptive and therapeutic potentials of regression. Therefore, they identify and accept the therapeutic potentials of regression without the same caution shown by Freud and Alexander.

Kris (1975) identified two categories of regression in differentiating between ego regressions resulting from ego weaknesses and regressions which were evident during different types of creative processes. He believed that in many cases the ego could control its own regression and make use of primary process without being

overwhelmed. The creative process was an example of a controlled regression, to primary process, resulting in an overall enhancement in functioning. Kris (1975) states:

> The ego's control over regression concerns a wide area of psychological problems. It was first noticed in the study of productive or creative activity, and in this connection described as the primary process in the service of the ego (Kris, 1934). Soon a wider set of implications became apparent. The control of regression forms one of the nuclear parts of the integrative functions of the ego, which include the ego's capacity to limit its own functions (Hartmann, 1939a) (p. 263-264).

Kris (1975) labeled the controlled regression "regression in the service of the ego." Thus he identified regression as a basic and necessary ego function within normal adaptive functioning. Hartmann (1964) also indicates that regression offers the potential for healthy adaptation "... in which adapted, and normal, behaviors of adult persons is actually achieved by way of regression" (p. 59).

Regression in the service of the ego is a controlled, benign regression by a healthy ego which differs from the malignant regression resulting from a weakened ego. The healthy ego, through regression, is able to access and integrate all parts of the psychic apparatus, including primitive and primary process aspects, without fear of disorganization or disintegration. Thus Hartmann (1964) states:

> These phenomena too must be looked at from the view point that to achieve optimal adaptation more primitive functions may be needed to supplement the highly differentiated ones (p. 60).

Kris (1975) believes the controlled regression has application in analysis by facilitating the process of free association and the use of insights. However, he does not equate regression with the emergence of the transference neurosis as others do.

Kris indicates that the therapist must always be careful with the phenomenon, despite its therapeutic potentials, since patients can lose contact with the therapist if they regress too far. He believes patients can also resist the regression due to fears of disintegration, indicating the importance of structural factors and the patient's potential difficulties in maintaining integration in a regression.

Kris also believes the depth of the analytic regression cannot be equated with the patient's increasing loss of control or its utility. Thus a deeply regressed patient could potentially still do analytic work. He also notes the variability between patients in how deeply they can regress and still make use of the analysis, indicating that differences probably result from early developmental factors.

Finally, Kris encourages the analyst to allow for their own regression in the service of the ego in order to creatively direct the analytic work. Thus, Hartmann and Kris have introduced regression as an essential aspect of the analytic process in facilitating both the patient's and therapist's associations. It can be inferred that Kris believed the therapist must regress with the patient in order to make the analysis fruitful, introducing a relational element to the process.

Anna Freud: Regression in Child Development and Child Analysis

The work of Anna Freud (1963) is significant in establishing regression as a normal and expected complement to progression in child development. Thus, her work deals with the adaptive potentials of regression identified by Hartmann (1964) and Kris (1975). She also

addresses the pathological aspects of regression and therefore provides a balanced perspective of the phenomenon.

Anna Freud conceptualized malignant regression along the same lines as Freud (1912a/1963) and Alexander (1956), as a return of the libido to an infantile dependency which is not temporary and therefore exerts a regressive and disorganizing pull on all functioning. In contrast, regressions in normal development are temporary ego regressions which do not involve a return to a fixation point but the retracing of the most recent path of progression. Therefore, it is sometimes possible to distinguish a healthy from a malignant regression based on whether or not all areas of functioning show regression. Anna Freud (1963) states:

> There is one distinguishing characteristic of ego-regressions to be noted, irrespective of the various causative factors. In contrast to drive regression, the retrograde moves on the ego-scale do not lead back to previously established fixation-points. Instead, they retrace the way, step by step, along the line which had been pursued during the forward course. This is borne out by the clinical finding that in ego-regression it is invariably the most recent achievements which is lost first (1963, p. 135).

Anna Freud (1963) indicates that in child analysis, the temporary ego regression is used and encouraged, through the setting and the technique, to reduce the child's defenses and controls. The regression leads to a relinquishing of secondary process with the emergence of primary process functioning. Here Anna Freud has outlined a benign regression which is temporary and reversible, and directed at freeing the child's fantasies and preconscious and unconscious processes so they can be worked through in the analysis. In the process she has

identified regression with shifts between primary and secondary process. She notes:

> ... as in every analytic setting, arrangements are made with the intention to prompt the child to reduce his defenses and controls and increase the freedom of fantasies, impulses, preconscious and unconscious processes. Under these conditions, it can be shown how the child's play and his verbal expressions lose gradually the characteristics of secondary process thinking, such as logic, coherence, rationality, and display instead characteristics of primary process functioning such as generalizations, displacements, repetitiveness, distortions, exaggerations (1963, p. 133).

This technique is significant in employing regression as a process involving a general functional shift into primary process rather than an enhancement of the associative processes. While the technique is applicable for children, Anna Freud warns against its use with adult patients indicating the distinction between the two types of analysis. However, other therapists, especially within the object relations school, do apply this technique to adults in an attempt to access early infantile states.

Menninger and Holzman: Regression as the Core of Psychoanalysis

The work of Menninger and Holzman (1973) is significant in outlining how benign regression is used in psychoanalysis. In general they believe that regression is an inevitable part of the analytic process with adults. They do not automatically view regression as a defense and resistance to treatment, but rather, as a singular, unitary phenomenon which becomes malignant or benign based on factors affecting the patient's capacity to maintain an observing ego.

Menninger and Holzman's (1973) use of regression with adults has some parallels with Anna Freud's (1963) technique with children. Thus,

the therapeutic technique extends beyond the facilitation of free associations. They indicate that regression allows the patient to access and reexperience the infantile transference neurosis so that it can be worked through. Hence the regression facilitates the analysis of the transference. The goal is to have the patient relinquish their infantile attempts at gratification substituting more mature ones.

Menninger and Holzman believe every patient is already regressed at the beginning of therapy, due to their psychopathology, and that the analysis removes any preexisting facades. Regarding the invariant role of regression in analysis Menninger and Holzman (1973) state:

> ... in psychoanalytic treatment, for one hour a day, the regression is there, to be heard and seen and utilized and ultimately resolved. It is sometimes called the 'transference neurosis,' but whatever it is called, this phenomenon of regression and its technical exploitation are of the very essence of psychoanalytic treatment (p. 47).

The patient's regression is facilitated by the analytic setting, including the more permissive attitude and silence of the analyst, the reclining posture of the patient, the quietness of the office, and the general reduction in external stimuli. However, Menninger and Holzman believe the major factor bringing about regression is the analyst's controlled frustration of the patient, which brings them into contact with their primitive wishes for gratification, dependency, and love. It is essential that the frustration not be absolute, however, since this would serve to fully recapitulate the failures of the parental figures. They believe the end result of this frustration, even though it is moderated, is regressed primitive rage towards the analyst.

The regressed patient is seen as showing behaviors reminiscent of childhood, in terms of immature speech and fluctuations in their self-estimate, body image, and ego ideal. Overall, the patient becomes more childlike in their attitudes and their emotional dependency upon the analyst. However, the regression is not considered a recapitulation of childhood since the observing part of the ego continues to function at a mature, secondary process level, allowing for the analysis to proceed with the patient maintaining the alliance with the analyst. Like Anna Freud (1963), Menninger and Holzman consider the shifts between primary and secondary process as a fundamental aspect of regression.

Menninger and Holzman state that only those patients who can maintain an observing ego and a therapeutic alliance in a regression should be considered for regressive work. Also, within the regression, the analyst must control the rate and depth of the patient's regression in order for it to remain benign and therapeutic. A malignant regression results when the observing part of the ego joins the rest of the ego in the regression, therefore losing the alliance with the therapist. Significantly, the role of the patient's observing ego and alliance are repeatedly cited by other therapists in the literature as factors differentiating the two types of regression.

Clearly, the relationship is important in this process, with the analyst serving to support the patient's observing ego and the alliance. However, Menninger and Holzman make it clear that the analyst does offer him or herself personally, in order to develop a new object relationship. Thus they indicate that there are limits to the

gratification of the patient and that the therapeutic relationship itself is not the agent of change.

Calder: The Problem of Too Little Versus Too Much Regression

Calder (1958) deals with the problems and possible causes of too much versus too little regression in analysis. His work is consistent with Menninger and Holzman's position that regression plays a central role in analysis and must be managed. His work is significant in addressing the possible causes for too much or too little regression and what the analyst can do to deal with either problem.

Calder's theoretical formulation of benign regression is similar to Anna Freud's healthy regression and Kris' regression in the service of the ego. When the regression is at an optimal level, it is benign and therapeutic since it facilitates free associations and the development of the transference neurosis, while remaining reversible. Calder (1958) states:

> ... ego regression may be healthy or unhealthy, depending on a number of characteristics, including its reversibility; i.e., whether the individual has control over the regression. (p. 558).

Calder states that difficulties in analysis can result from either too little or too much regression by the patient. A patient's inability to sufficiently regress was seen as a defense against the reactivation of infantile modes of gratification, which subsequently interferes with the development of the transference neurosis. Too little regression results from several sources, including early problems in object relations which interfere with the development of trust, oedipal level wishes, and various anxieties.

A malignant regression is the result of too much regression, where the patient cannot control the regression and it is no longer readily reversible. Calder cites that the dynamic causes for a malignant regression include the repetition in the analysis of preverbal traumatizing experiences, a psychotic transference to the analyst, and various anxieties. The genetic causes reflect the patient's defects in ego formation as a result of early object relations failures, an identification with a psychotic parent, and early traumatizing experiences.

In order to deal with a malignant regression, Calder suggests the analyst engage the patient in a mutual and more normal dialogue, become a more real object for them, sit the patient up, and focus on reality issues. Consistent with Anna Freud (1963) and Menninger and Holzman (1973), Calder's technique reflects the need to reinstitute secondary process functions and the observing ego.

Noteworthy here is the possibility that the malignant regression was brought on by the analyst's repetition of an earlier preverbal traumatizing experience for the patient. Calder also focuses on ego defects or structural factors as predisposing for malignant regression. Hence, he believes both relational and structural issues are focal in a malignant regression.

Frosch: Malignant Regressions as Severe Regressive States

Frosch (1967) also identifies benign and malignant forms of regression but focuses on the latter. His work is significant in understanding the nature and precipitants for a a malignant regression.

Frosch refers to malignant regressions as severe regressive states characterized by a persistent recurrence, irreversibility, intense affect, and an overall disabling effect on the patient's adaptation. The malignant regression also leads to problems in the therapeutic relationship which hinder the analysis.

Frosch believes the patient's loss of observing ego can lead to a lack of separation from the analyst, with experiences of engulfment leading to a psychotic transference where the patient confuses the analyst with an earlier object. All patients are potentially prone to pathological regressive states, but the nature and extent of the regression may vary in relation to the degree of ego integration which is maintained. Frosch agrees with Calder (1958) that early developmental failures establish predispositions to malignant regression.

Frosch opens the possibility, however, that malignant regressions may also be useful or necessary for therapeutic change. He believes malignant regressions can sometimes serve as necessary precursors to subsequent progression through the process of disintegration and reintegration. His view is consistent with Anna Freud's (1963) conceptualization of child psychic development, but extends it into adult functioning.

Significantly, Frosch questions the role of the analyst in precipitating a malignant regression. He identifies the analyst's technique, their personal fears and anxieties around regression, and their role as a real person as possible precipitants for a malignant regression. Frosch (1967) states:

> What actually evokes these [malignant regressive] reactions during analysis? Are there certain technical maneuvers which may intentionally or unintentionally bring to the fore such reactions? Is there anything the analyst does or does not do which will precipitate a severe regressive state? To what extent do expectations, fears, and anxieties on the part of the analyst contribute to the development of these reactions? This might be a particular factor to consider in analysts who view such reactions as inevitable in the course of analysis. Are these realities in the analytic situation which may be so threatening and dangerous to certain patients as to bring about regressive withdrawal?
>
> These questions are related to the nature of the therapeutic alliance in general as well as to what happens to it in the face of such severe regressive states. ...
>
> Allied to this question is what role the real person of the analyst may play in the fostering of severe regressive reactions (p. 500-501).

Frosch's questions are noteworthy in addressing the real aspects of the relationship between the patient and the analyst, suggesting that the malignant regression is a two person event.

Meissner and Giovacchini: Early Dyadic and Infantile States

Meissner (1981) and Giovacchini (1984) each indicate the importance of dealing with preoedipal issues in a benign regression. Their work is significant in identifying what states are accessed within the patient in a benign regression. Meissner (1981) indicates that the earliest dyadic object relations can be accessed within the regression and transference neurosis. Given the focus on dyadic issues he draws a parallel between the analyst's response to the patient's regression and the parent's response to a child's developmental demands. This metaphor is developed by other therapists in this review, indicating the unique nature of the relationship with a regressed patient. Meissner believes that initially the analyst must respond to the regressed, passive-dependent aspects of the patient's

infantile neurosis. However, by the end of the analysis, there is a fostering of autonomy and independence in the patient.

Given his metaphor, Meissner focuses on the strength of the therapeutic relationship, as well as structural factors, in determining whether the regression remains benign or becomes malignant. He believes that early failures in object relations development lead to structural defects and the patient's inability to tolerate anxiety. It is important to note that while Meissner focuses on the therapeutic alliance he does not equate it with the real aspects of the therapist, the patient, or the relationship unlike Frosch (1967) and some of the subsequent therapists.

Giovacchini (1984) extends Meissner's (1981) formulation stating that the benign regression accesses a pretraumatic infantile ego state. Within the pretraumatic state he believes the patient can slowly assimilate positive integrative experiences and, specifically, can internalize the nonanxious aspects of the analyst as observing ego. Giovacchini's position is significant since he breaks from previous writers in stating that the depth of the regression is critical, not in accessing the earliest trauma, but in returning to a pretraumatic state.

Giovacchini believes the regression approximates the embryonic and amorphous self representations of the early infantile ego. The regressed ego loses its previous synthesis but does not regress totally. The ego regresses selectively and unevenly, while maintaining its basic structure. Thus a less regressed part of the ego remains available to observe the regression of the other parts. He does not

believe that therapeutic change results directly from the regression itself, however, but rather, from the constant analytic setting and consistent use of interpretations. The interpretations serve to provide the patient with structure within the analysis and regression. Significantly, these elements appear to reflect a focus on the process of the regression as well as the products.

Giovacchini's formulation is important since it identifies and describes a specific state, rather than a general regressed state, which maximizes therapeutic change. He has therefore given some structure to the nebulous concept of regression with an implicit indication that there is a process specific to regression which extends beyond its utility in facilitating the transference neurosis. The next section is meaningful in identifying the role of the therapeutic relationship within the process of a patient's regression.

Frijling-Schreuder: The Therapeutic Relationship

Frijling-Schreuder (1966) focuses directly on the therapeutic relationship as a determinant for malignant regressions. Thus, he introduces the real aspects of the relationship into the process. Drawing a parallel with a child's normal regressions, which become traumatic when a parent is unwilling or unable to tolerate them, he believes the patient's regression also becomes traumatic or malignant when the analyst does not accept it.

Consistent with other therapists, Frijling-Schreuder believes regression is necessary in analysis in facilitating the reliving and subsequent resolution of infantile conflicts. Important to the

process, he believes the patient places demands upon the analyst to join in the regression, as an empathic response, so that they do not feel alone or misunderstood. In this process the analyst must deal with primary process content and functioning while still having access to secondary process, integrative functions.

Frijling-Schreuder states that the patient's benign regression becomes problematic and pathological when the analyst thwarts it, possibly due to fears over dealing with their own unresolved transference issues. He believes the analyst's intolerance of the patient's regression is communicated in many indirect ways, including hasty interpretations, blind spots, restlessness and impatience, tense silence, and interpersonal distance. Consequently, Frijling-Schreuder believes the analyst must always be sensitive to their defenses against regression. If analysts become repeatedly countertherapeutic for their patients he advocates their own analysis.

The position taken by Frijling-Schreuder clearly makes the benign regression a dyadic process requiring the full participation of the analyst. Hence, malignant regressions are also dyadic when they result from the analyst's inability to tolerate any regression.

Jaffe: The Therapist's Response to Regression

Jaffe (1986), like Frijling-Schreuder (1966), takes the position that the analyst needs to regress with the patient in order to subjectively experience and understand their thoughts, feelings, and experience. His work is significant in focusing on the dyadic nature of a benign regression and what this demands from the therapist.

Jaffe presents the process through which the therapist achieves an empathic, subjective understanding of the patient in stating:

> In analysis there is a manifest content of the patient's conventional communications and also a subtext based on more primary process thinking: unconscious fantasies, memories, conflicts. The analyst is "primed" to permit his own unconscious to resonate with the patient's. The analyst learns to experience his own internal processes in learning about the patient, through a controlled regressive pull induced by the patient's regression via trial identification, or empathy. Through his resonating regression, the analyst is able to use his observing ego to recognize his own conflictual areas. This provides an affective quality necessary for true understanding and interpretation. The interplay is between the merging pressures and those of redifferentiating, separating, individuating.
>
> There is regression in the patient and in the analyst, in effect a set of subsystems that can function or malfunction. The empathizer maintains the integrity of the self intact and does so by placing the self into the other's intrapsychic reality without being threatened by the other's experience; thus the empathizer is able to use cognitive functions effectively (p. 231).

Jaffe believes both the patient and the therapist have demands placed upon their observing ego to remain intact and secondary process oriented, while descending into primary process realms in a regression. When a therapist is able to follow a patient, by regressing along with them, empathy is maintained in a manner similar to the deep empathic relationship between a mother and child. Jaffe also draws very clear parallels between the mother and her child and the relationship between the analyst and a regressed patient, with the former as a model for the latter.

Jaffe states that this form of relating and communicating between mother and child is affective, and often without cognitive elements. For example, "the child guesses mother's mood without being told about it" (1986, p. 232) reflecting a process of merger and separation by the

mother. Jaffe believes the good mother is able to merge and empathize with her child's experience (i.e. of pain) in a transient manner and then separate in order to act appropriately in response to the child's needs. Pathology results when the merger is not transient but ongoing, or when the mother fails to use the empathic communication to effectively meet the child's needs at that moment.

Jaffe believes the analyst should act like the good mother in relation to the regressed patient. It is also significant that he directly ties affective communication to the regression, attributing equal importance to both the affective and cognitive processes which operate within a regression.

Jaffe's work, which is the most current psychoanalytic literature in this review, presents what appears to be a shift and movement by some analysts towards a dyadic, object relations model which integrates the earlier focus on ego functions where structural factors were focal. Thus, regardless of theoretical orientation, various therapists may view regression in a fundamentally similar manner as a result of the nature of the phenomenon. Consequently, Jaffe's work provides an appropriate transition to the following review of object relations theory. The discussion of object relations theorists focuses primarily on benign regression within the context of a dyadic process.

Object Relations Theory and Regression: Introduction

It is a fundamental assumption of object relations theory that both healthy and pathological development originates within the dyadic mother-infant relationship. The primary focus on the earliest dyadic

relationship results in a different approach to therapy and a different concept of regression relative to psychoanalysis. In object relations theory the dyadic process, rather than interpretation, is focal in the treatment. Therefore, regression is viewed as a dyadic process within the therapy.

The interplay between progression and regression is also central to the object relations perspective. Balint (1968) defines regression as the emergence in therapy of "primitive forms of behaving and experiencing, after more mature forms have firmly established themselves" (p. 130). Winnicott (1975) similarly defines regression as "the reverse of progress" (p. 280). In order for this reversal to be therapeutic he believes there must be a relatively stable and complex level of ego integration and development already in place, so that the regression remains organized. When the integration is not stable there is a potential for disorganization and a malignant regression. Clearly, Winnicott believed that healthy regression required some prior healthy progression. This theme will be elaborated throughout this section of the Literature Review.

In this section, the work of Michael Balint, D. W. Winnicott, and Harry Guntrip will be discussed. In addition, the work of Sandor Ferenczi will be reviewed. While Ferenczi is not identified directly with the object relations school his work in the area of benign regression was seminal and far reaching for later writers. In order to provide an historical continuity, his work will be dealt with first.

Each of these writers presents a detailed formulation of the technique and theory underlying the use of benign regression in

therapy. Their work reflects the assumption that regression is a basic psychological phenomenon which should be utilized therapeutically. The ambivalence towards regression often seen in the psychoanalytic literature is not evident in the object relations literature. In this review each writer serves to highlight a specific area relevant to an understanding of the patient's benign regression in therapy.

Sandor Ferenczi

Beginning in the 1920's, Sandor Ferenczi (1930) attempted to introduce some revisions and alternative approaches in psychoanalytic technique. He believed that the frustrating aspects of psychoanalysis, the analyst's "rigid and cool aloofness" (p. 436) and "didactic and pedantic attitude" (p. 432), were ultimately counterproductive to the therapeutic process.

Ferenczi (1930) believed that these aspects of analytic technique resulted in a recapitulation of earlier parent-child authority struggles in which overt compliance belied covert dissatisfaction and rebellion. For the patient, this created a repetition of their infantile trauma leading to resistance in the therapy rather than working through to resolution. Ferenczi therefore advocated less frustration and greater gratification of the patient. He believe the shift toward gratification would result in reduced resistance, leading to a greater facility for recollection by the patient.

As a result of his changes in technique, Ferenczi's patients were able to regress in the therapy. In this process he observed a number of interesting effects involving the patient's regressive experiences.

He believed that in the course of the regression patients were able to reexperience their original infantile trauma in a manner which contributed to enduring character changes. Since Ferenczi believed that all intrapsychic conflicts had their origin in early parental failures, he was convinced that a benign regression provided the means for resolving these conflicts. Therefore, the analysis was not complete until the early traumas were recalled, reexperienced, and worked through in a benign regression.

Ferenczi's use of regression was a forerunner of how it was later used in psychoanalysis by Menninger and Holzman (1973) and others. However, in considering the nature of the patient's early infantile traumas, Ferenczi broke with instinctual-drive theory in stating that all intrapsychic conflicts and forces were the result of an original conflict between the developing infant and child and significant others in their lives. Thus Ferenczi shifted the focus completely to the patient's object relations.

Ferenczi also became displeased with the use of free association, stating that it reflected a "conscious selection of thoughts" (1931, p. 470) drawn from more mature, reality oriented parts of the personality. In its place, he urged his patients to "surrender to the impressions, tendencies, and emotions which quite spontaneously arose" (1931, p. 470) in them. He believed this would access more primitive parts of the personality. The result was that his patients became more childish in their speech and behaviors having entered a regression.

In working with regressed adults, Ferenczi often found himself entering into games which were analogous to what was seen in play

therapy with children. He noted that one game could be called "questions and answers" (1931, p. 471). This game demanded that he not adhere to the technique of interpretation, but simply ask questions. In asking questions, he also became aware of the need to present them to the patient in a child's language and for a child's comprehension. Hence, questions had to be simplified and relatively concrete. When Ferenczi failed to simplify the questions, his patients would accuse him of having been "clumsy and having, so to speak, spoilt the game" (1931, p. 471). He believed that the use of interpretations with regressed patients was not successful. The use of adult language was seen as creating a gulf between the patient and the therapist, who were consequently speaking different languages.

Ferenczi compares the regressed state to childhood and a "complete lack of will" (1949, p. 238), when the infant is completely dependent upon the mother. When a patient is regressed, they are seen as giving up all ties to the present and sinking "completely into the traumatic past" (1949, p. 234). Here the therapist serves as a bridge between the patient's regressed state and the present. Ferenczi believed that questions were useful in helping the regressed patient deal with their infantile affects and experiences. He also believed the therapist should help the patient to not feel alone in reexperiencing their early traumas (Ferenczi, 1949).

Ferenczi offered specific guidelines on the behavior and technique of the therapist while working with regressed patients. He believed the therapist should attempt to meet the patient, as much as possible, through continued "patience, understanding, goodwill and kindness"

(1931, p. 473-474). When the therapist is able to do this, the patient comes to trust that past traumatic experiences will not be repeated with the therapist. Given this sense of safety, the patient can then sink into the regression and their experiences of the past.

Ferenczi draws an analogy between the behavior of the analyst and the "tender mother" who allays her child's fears, troubles, and concerns. He refers to good mothering as the capacity to be available with understanding, with tenderness, and with complete sincerity. This approach allows children to recover readily from traumas. In therapy the therapist's similar availability allows patients to safely regress to a period of early dependency which Ferenczi calls the phase of "passive object-love." This phase involves the earliest object relationship, characterized by the wish for total and unconditional love within a dependent relationship. In the course of the regression Ferenczi also believed patients could enter a a pre-traumatic state.

Ferenczi also believed that when the therapist was able to maintain the role of the tender mother and avoid the failures of the original dyadic relationship, the patient was able to maintain the real personality and presence of the analyst, while reliving early infantile experiences. Through this process the early infantile traumas were remedied with a resolution of the splitting which occurred from the early traumas.

Ferenczi used the model of the good mother as the vehicle for bringing about healthy progression through a benign regression. Thus, he conceptualized regression as a natural return to early infantile states within a relationship which did not recapitulate the failures of

early parental objects. Ferenczi's work is significant in its focus on the relational factors needed to foster and maintain a benign regression, and on the characteristics of the regressed patient, which he believed paralleled the functioning of a child.

Michael Balint: Malignant Versus Benign Regression

The work of Michael Balint (1968) represents an elaboration and extension of Ferenczi's work. Unlike Ferenczi, however, he also focuses on malignant regression and the way in which it differs from benign regression. Balint described malignant regression as the patient's regression in pursuit of infantile instinctual gratifications rather than growth and change. Consequently, this form of regression was a major source of resistance to the therapeutic process. Balint described benign regression as the patient's pursuit of "recognition", rather than gratification, within an object relationship. This type of regression was a therapeutic ally, since it allowed the patient to deal with dyadic conflicts within the relationship with the therapist.

In order to fully appreciate Balint's work on regression, it is useful to initially discuss his theoretical model of the nature of the primary dyadic conflicts which the regression accesses. Balint uses the term "basic fault" to describe an enduring, underlying structural deficit in ego and character development which is the primary source of all psychopathology. The origin of the basic fault is tied to what he calls a "lack of fit" or a discrepancy between the infant's "bio-psychological needs and the material and psychological care, attention, and affection available" (1968, p. 22) from the primary object.

While Balint acknowledges that the lack of fit can arise from congenital deficits in the infant, he emphasizes the lack of fit between the maternal care and the needs of the infant. A lack of fit is evident when the mother's care of her infant is "insufficient, deficient, haphazard, overanxious, overprotective, harsh, rigid, grossly inconsistent, incorrectly timed, overstimulating, or merely un-understanding or indifferent" (1968, p. 22). Balint believed the resulting structural fault left the infant, and later the adult, feeling as if someone had failed to provide them with what they really needed.

Balint states that it then becomes the task of the therapy to "inactivate the basic fault by creating conditions in which it can heal off" (1968, p. 166). To do this he believed the patient must be allowed to enter a benign regression and regress to an object relationship similar to the one which was present when the fault was created, or even to a period before this.

In terms of technique, Balint indicates that the therapist needs to respond to the patient in a manner which conveys a "presence of fit" which simply means providing what the patient needs in terms of sensitivity, awareness, and empathy. Responding to the patient in this manner creates the proper setting for the regression and a return to a primitive form of relationship. The result of this process for the patient is the development of a new object relationship with the therapist, leading to a healing of the basic fault and growth.

Balint believes that the patient's benign regression is an essential component of all analytic therapy. He states that the

regression is always a two person event which parallels the primary dyadic relationship. The dyadic focus is a basic and essential point for technique since it now becomes important for the therapist to agree to become a part of the regression. Here the therapist's technique must allow for responses to the patient which permit the regression to proceed. In order to do this, the therapist and the patient must create an environment or atmosphere where they can tolerate the regression together.

Balint believed that any gratifications or frustrations of the patient should be managed in a way that allowed the regression to proceed without creating an inequity in the therapeutic relationship. He believed it was counter-therapeutic and counter-regressive for the therapist to maintain a position of control or dominance. This lack of fit could contribute to a regression becoming malignant.

Balint states that the therapist needs to deal with "the child in the patient" (1968, p. 182) since the regressed patient often manifests primitive and childish behavior. At times the regression results in the patient functioning on an essentially nonverbal level. Therefore, the technique must consider the form of communication and language used since it will determine what the patient says and does, and the depth and degree of the regression. Balint indicates that the therapist should not force their language or interpretations on the regressed patient since this compels them to operate at a secondary process, triadic level.

Balint believed that regressed patients were unable to use interpretations to organize themselves, and that they could serve to

impede the regression. He therefore encouraged the therapist to tolerate and allow the patient's productions to "remain incoherent, nonsensical, unorganized" (1968, p. 177) during the regression. While the patient is regressed, the therapist should serve as an interpreter between the patient's adult self and their more primitive nonverbal behavior, and as an informer to the patient of what is going on. Upon the return to a secondary process level of functioning, Balint believed the patient could then organize and work through these productions. While the patient is immersed in primary process, the therapist should accept that the regression is often a nonverbal process.

Although the patient attempts to use the regression to establish a primitive object relationship, Balint believed that it is not necessary to interpret what the patient wants. Instead, the therapeutic setting should allow the patient to create a benign and therapeutic object relationship with the therapist.

Balint states that in order to maintain the patient's benign regression the therapist should remain unobtrusive and ordinary, with the goal of freeing the patient from external impingements and demands. The therapist should be neither too far from the patient, since this is experienced as abandonment, nor too close, since this is impinging and makes the patient feel encumbered. In keeping a proper distance, the therapist conveys their sensitivity to the changing needs of the patient. Through the use of this technique, the patient is given the opportunity to use the therapist as a primitive, primary object who can recognize their needs and remain with them. For Balint, the

therapist's attunement to the patient is the essential component for therapeutic change.

While developing the importance of the therapist as an object, Balint states that what the therapist offers is not themselves, but rather a climate or atmosphere within the therapeutic setting. In order to maintain this environment, Balint believes the therapist needs to function as a caretaker and manage the regression since the patient "has temporarily given up the protection of his adult or perhaps false, self-who needs management" (1968, p. 111).

Balint also identifies several things the therapist should not do in order to avoid destroying the therapeutic atmosphere in a benign regression. First, they should not interpret all of the patient's actions as transference. Second, they should not act as a distinctly separate object from the patient. Third, they should not become omniscient or omnipotent in the patient's eyes since this invites the development of malignant forms of regression.

Balint's work is significant in its focus on both relational and structural factors as critical elements in determining the potentials for benign and malignant regression. Thus the regression results in therapeutic change through the patient's development of a new object relationship with the therapist, and not just in conflict resolution. It is also significant that Balint focuses on the therapist's attunement to the patient's needs as the mechanism for change. The importance of the therapist's attunement to the patient is elaborated in the next section, on the work of Winnicott.

D. W. Winnicott

The work of D. W. Winnicott, reflects an ongoing dialogue between his clinical experiences with children and adults and the development of his theory and therapeutic technique. His conceptualization of benign and malignant regression was influenced by his observations of infant and child development.

Winnicott believed that for therapy to be successful, "there had to be a regression in search of the true self" (1954b/1975, p. 280). Winnicott describes the true self as that part of the individual which represents their real inner needs and spontaneous actions. He believed that the true self was not allowed to develop normally when maternal failures in attunement lead to compliance by the infant and child. Here the normal process of the dyadic relationship was reversed; the mother did not meet the infant's needs and expected the infant to meet her needs. Winnicott conceptualized that in response to this failure a "false self" developed, which was a defensive maneuver and an attempt to protect the true self from destruction. Thus, the false self was seen as an expression of hope that someday there could be a correction of the early maternal failures.

In the development of the false self Winnicott believed that the true self was protected against further failure experiences through "a freezing of the failure situation" (1954b/1975, p. 281). In this situation the true self awaits the opportunity to be "unfrozen" and reexperienced. For Winnicott, the process of "unfreezing" the true self can only be achieved through a controlled or benign regression within a holding environment.

Winnicott conceptualized benign regression as a latent capacity of the individual which allows for a reworking of the past in order to free the true self. In order for the regression to be organized and therapeutic, and not malignant, the ego must have already achieved some degree of integration and complexity in its organization. Winnicott indicates that patients with a well developed observing ego can readily recover from the regression at the end of the session. Where the observing ego is weak or lost in the course of the session, the patient's regression does not end with the session but continues, at times requiring that the therapist manage the patient's functioning between sessions.

For Winnicott (1954a/1975; 1960a/1965) the process of a benign regression begins with the therapist providing a setting which allows the patient to experience a sense of confidence and reliability. By providing what Winnicott refers to as "good enough mothering" or an attunement to the patient's needs, the therapist creates a holding environment which allows the patient to regress in a controlled manner to an earlier state of dependence, and to a place where the true self can be reached.

Winnicott sees the patient's regression as an "organized return to earlier dependence" (1954b/1975, p. 291) which parallels the early infant-mother relationship. Winnicott adds that getting to this point in the therapy often involves much time, because the patient is usually wary of entering into a dependent relationship based on their past object relations experiences. However, when the patient can regress to

a primary dependence upon the therapist, therapeutic change becomes possible.

Winnicott believes that a regressed patient can achieve an ego state prior to the original infantile trauma, in which it can better assimilate positive integrative experiences. Initially, however, the therapist can only deal with the patient's false self. With maintained attunement by the therapist, the patient can get in touch with their basic processes or true self. Subsequently, the true self is able to emerge and become fully a part of the ego, while discarding the false self, which is no longer needed. This process eventually leads the patient to become more independent and real.

Winnicott states that in maintaining attunement the therapist should cooperate with the patient by following their unique process; the therapy should have its own pace and course which originates from the patient and not the therapist. Winnicott (1963b/1965) notes that cooperation involves attending to what the patient needs by giving ego support to ego processes. Providing this support to the patient early in the analysis corresponds to the mother's support of the developing ego of the infant. Similarly, the patient's ego remains weak and easily disorganized when the necessary support is not provided by the therapist.

Clinically, Winnicott observes that by strengthening the patient's ego the therapist helps the patient to experience and express, within the present, their rage over early parental failures without fear of disorganization. Winnicott believes that the therapist's failures in

attunement are used by the patient to affectively reexperience the early failures.

Winnicott cites three management functions the therapist should provide for the regressed patient: (1) The therapist should attend to the quality of the therapeutic setting; it should be relatively quiet and free from impingements upon the patient. (2) The therapist should provide what the patient requires, by avoiding undo intrusions through interpretations, by not making the therapist's presence too apparent, and by letting the patient be and do what they need to. (3) In some cases the management will need to extend outside the session requiring that the therapist involve the family or use inpatient hospitalization to maintain the holding function.

Winnicott (1956) warns that interpretations, particularly during the early stages of the therapy, may be problematic and counter-therapeutic with a regressed patient. The setting and environment are always primary, while interpretations are secondary. He believes that in using interpretations the therapist risks losing touch with the regressed patient's basic needs.

Winnicott (1954a/1975) notes that regression in analysis was sometimes considered dangerous and potentially pathological. He acknowledges that a danger exists, but not in the benign regression itself. He believes the danger is in the analyst's unwillingness to "meet the regression and the dependence which belongs to it" (p. 261). He also believed that the more quickly and readily the analyst accepts and meets the patient's benign regression, the less likely it is that the patient will enter into a malignant regression. This reflects

Winnicott's basic belief that the therapist should always adapt to and follow the patient's process.

Harry Guntrip

Consistent with Winnicott, Guntrip (1969; 1971) sees "ego weakness", arising from early maternal failures in the primary object relationship, as the source of all pathology and deficits in development. His work is significant in addressing the structural nature of the ego weakness in terms of splits in the ego. He therefore also addresses in greater detail aspects of malignant regression.

Guntrip (1971) states that an inadequate mother makes the infant intensely aware of its weakness and helplessness. The infant feels helpless and weak when the mother excites the infant's needs, in part simply by her presence, while ultimately refusing or failing to satisfy these needs. The infant's sense of weakness interferes with the development of a sense of wholeness, and hence ego integration, since the infant experiences acute states of fear as a result of feeling helpless to have its needs met.

Guntrip hypothesizes that the infant seeks to take flight from this intolerable state in order to survive. However, due to its total dependency on its environment and the maternal object, the flight takes the form of a retreat into an internal psychic world. As a result, Guntrip believes that the once whole but weak ego fragments and splits in order to survive. Thus he accepts Fairbairn's (1944/1952) concepts of the central ego, the libidinal ego, and the anti-libidinal ego.

For Guntrip, however, this initial split does not fully resolve the infant's experience of weakness and continuing fears of being overwhelmed and lost. The infant's anxieties and fears in relation to all objects come into conflict with their needs for object relatedness. As a result of this dilemma, which cannot find resolution through withdrawal into an internal object world, the libidinal ego undergoes another and final split. The result of this ego split is "an active suffering and a passive regressed libidinal ego" (1969, p. 82).

The regressed ego, which Guntrip also refers to as the "schizoid ego", is regressed and hidden from contact with both external and internal objects. Guntrip believes the regressed ego includes Winnicott's "true self." Therefore, the regression of this part of the ego is intended to preserve the core and real aspects of the self. However, the resulting regression by this core component of the ego exerts a strong regressive pull on all other parts of the ego, both internal and external, to also regress and withdraw totally from contact with the world of objects.

Guntrip describes two forms which this regression can take. The first form involves a pathological flight from the world of objects in order to obtain relief from the fears of ego loss. In the extreme, this regression can reflect a longing for death and a total avoidance of objects. The classic example of this is the schizoid suicide. This regressive flight from objects is the source of all pathology according to Guntrip and therefore a malignant regression.

For Guntrip, the regressed ego and its constant regressive pull away from objects and the external world represents an ongoing

potential for psychic disorganization and breakdown. The pervasive effects of the regressed ego lead to problems in the development of all subsequent object relationships.

The second form of regression identified by Guntrip relates to the individual's wishes for rebirth associated with the return to the security of the womb. This form of regression reflects a state of hope and becomes an ally of the treatment process. Hence, it represents a benign regression.

Guntrip, like Winnicott, makes his approach to therapy a natural extension of his theoretical formulations. He believes the ultimate problem for therapy is how to initiate ego growth in a patient where this process has been arrested. For Guntrip, the answer involved converting the patient's pathological regressive trends into rebirth and regrowth. Thus, he believed that the therapist must find a way to allow the patient to use a controlled, constructive, benign regression in place of the uncontrolled and involuntary regression which would result from succumbing to the regressive pull of the regressed ego.

Guntrip believed that when the therapist acts as the good mother, by offering an object relationship in which there is understanding, acceptance, and a safeguarding of the regressed ego's rights, the patient is able to regress to the level of the regressed ego. This regression ultimately results in an unfreezing of the self so that rebirth and regrowth can occur. Guntrip believed that all patients, regardless of the severity of the pathology, needed a benign regression which is controlled and supported by the therapist.

Guntrip believes that the more intensely the patient experiences the need for a benign regression, the more fearful and consequently the more resistant they become to the regression. One of the primary resistances comes from the determined opposition of the anti-libidinal ego, since it contains the frightened infant's fears of weakness. The operation of the anti-libidinal ego results in a denial of all needs, especially passive-dependent needs, and therefore it becomes intensely rejecting and punitive of the libidinal ego's attempts at developing the therapeutic relationship. Guntrip believed that in order for the therapy and the regression to proceed, the resistances of the anti-libidinal ego must be resolved. The benign regression can only occur when the patient has developed a sound relationship with the therapist.

Guntrip believed the goal of the regression was to allow the patient to safely reexperience their basic primary dependency needs within the relationship with the therapist, in order to nullify and change the effects of early parental failures. Fundamentally, he believed the patient was seeking "good enough mothering." In order to meet the patient's needs for "good enough mothering", the therapeutic environment must provide the patient with a sense of security, and the therapist must be willing to accept the patient's dependency needs, while providing what is necessary for independence.

Guntrip's view of the therapist's role in relation to the patient is analogous to the views of Winnicott and Balint. Guntrip identifies three stages of the therapeutic process: the oedipal conflict, the schizoid compromise, and the regression and regrowth. Each stage is complex, and patients do not always go through them in the same order.

However, Guntrip believes that invariably the therapy ends up dealing with oedipal issues first before moving into schizoid issues. Working at the oedipal level before entering into a regression is necessary in order to support and strengthen the ego. At the schizoid compromise level, contact can be made with the withdrawn schizoid ego so that regrowth can begin.

In order for the patient to enter a benign regression and regress to the level of the schizoid ego, Guntrip outlines three stages for what the patient needs from the therapist. In the first stage the therapist needs to act as a parental figure who can protect the patient from gross anxiety, and provide support and reassurance. This may be resisted as a result of anti-libidinal influences, but is eventually welcomed when the resistances are relinquished. The second stage involves analyzing the failures of past relationships, in the form of transferences, so that they do not block the patient's growing dependence upon the therapist. In the third stage the patient needs "the basically non-erotic love of a stable parent" (1969, p. 336). This type of relationship results in growth and maturity, and the capacity to be separate without feeling isolated.

In addressing what makes a benign regression valuable and necessary Guntrip assumes that there is a basic personality structure which needs to be changed in order for growth and maturation to occur. Consequently, it is necessary to access and deal with the patient's hidden inner core which contains their early traumatic and failure experiences in relation to the mother. This hidden core can only be accessed directly through the use of regression.

In summary, the process of a benign regression in object relations theory is unique, relative to psychoanalytic theory, since its curative elements do not derive from an understanding of the past. Rather, the curative elements are in the reliving of the past, but this time in the company of a good enough mother. Therefore, structural change and growth is a result of the process of the regression, within the context of the therapeutic relationship, and not the content of the therapeutic work.

Hypothesis: The Role of the Therapeutic Relationship in Determining Whether Regressions in Treatment are Benign or Malignant

The literature indicates that a patient's regression within the process of the therapy can be benign or malignant. It is the hypothesis or presupposition of this research that the nature of the therapeutic relationship, once the treatment begins to unfold, is critical in determining whether a malignant or a benign regression emerges in treatment. It is assumed that other factors, like the patient's early object relations and resulting ego and character structure, contribute to tendencies towards one form of regression versus the other. However, given these considerations, it is still hypothesized that the transactions in the therapeutic relationship serve as critical precipitants for either form of regression.

Specifically, it is assumed that as the therapeutic relationship develops and the patient begins to feel more secure and held, there emerges a natural regressive pull towards an infantile dependency

relationship. The patient therefore seeks to create this relationship with the therapist.

When this regressive tendency emerges there appears to be a critical period or periods in which the therapist must respond to the patient's needs in a specific manner. At this point, the therapist must provide a reciprocal therapeutic response to the patient's gestures and movements towards regression and dependency. In most cases, however, these needs are embedded in transference driven, interpersonal transactions which seek to recapitulate earlier parental failures. Here the patient unconsciously plays out a piece of the transference with the therapist. This is done with the potential for the patient either feeling held and appropriately responded to, or rejected and misunderstood. The former outcome leads to the hope of a new object relationship and a secure dependency, while the latter leads to the despair of always being locked in the old object relationship.

What is critical to the treatment at this point is not the content of the therapist's response to the patient, but the process of the response. It is the process which genuinely conveys the therapist's acceptance or rejection of the patient's gestures and needs for an infantile dependency in relation to them.

When the therapist fails to respond to the patient's needs for dependency, but does not fully recapitulate the transference expectations, the patient is thwarted in obtaining these needs and does not regress any further. In effect, the patient's involvement and compliance is maintained, with the hope that the therapist may later meet their dependency needs. However, when the therapist fails to

respond to the patient's dependency needs in a manner which recapitulates the transference expectations based on early dyadic failures, then the patient is at risk to enter into a malignant regression. This is a regression which will most likely recapitulate the patient's infantile responses to early failures by the primary object, making the transference recapitulation complete.

In order for the regression to be benign, the therapist has to carefully avoid recapitulating earlier failures. At the same time they must accept the patient's needs for dependency, as well as the accompanying regression to fulfill these needs. This acceptance is communicated nonverbally by the therapist. With this approach the patient feels there is hope for a new beginning, and is in a position to enter and make use of a benign regression.

The Hypothesis as Preconceived Beliefs

Unlike traditional research, phenomenological research does not attempt to test specific hypotheses. The methodology does not allow this and the philosophical orientation does not intend this. Thus, hypotheses are not presented to be tested. This research is therefore divergent from the mainstream in offering a hypothesis. As stated in the Introduction, however, the hypothesis is offered for exploration within the Discussion, rather than in an attempt to seek any formal validation, which is not possible given the methodology.

The hypothesis is drawn from the researcher's direct experiences with regression, extensive readings on the subject, and insights and intuitions on the nature of the phenomenon. It is also embedded in a

theoretical orientation which draws deeply from object relations theory. These, and other factors, have contributed to the researcher's preconceived beliefs and assumptions about regression. These beliefs and assumptions reflect a form of bias, in terms of expectations, for what the research will reveal. The hypothesis therefore serves to formalize the researcher's informal, unstated assumptions while working on the research.

CHAPTER III

METHODOLOGY

Introduction

The research uses a phenomenological methodology, with therapists as subjects. It draws on their experiences with regressed patients in order to provide a detailed description and understanding of benign and malignant regression within the clinical setting. These phenomena are examined in terms of the therapist's unique experiential understanding.

In working with patients, many therapists simultaneously or sequentially perceive, feel, know, and analyze the events within the patient, and the process within the therapeutic relationship, not to mention their own feelings and countertransference reactions. This unique multilevel mode of experiencing a phenomenon, which only comes after years of training and experience, was drawn on to obtain the data for this study.

The therapist's ability to cognitively and affectively understand the patient's experiences can also result from a parallel regression with the patient (Jaffe, 1986). Thus, as participant observers in the clinical setting, therapists should be fertile sources of data on regression. It was anticipated that their experiences would provide a penetrating understanding of what regression is, as a phenomenon in the treatment setting, and what might bring it about. Consequently, the research uses interviews which focus on the clinical experiences of therapists with patients who regressed during the therapy.

The Phenomenological Methodology: An Overview

The research follows Colaizzi's (1978) "understanding-descriptive methodology" (p. 57), which provides both a description and an understanding of the phenomenon being studied. Colaizzi states that both understanding and description can be achieved through the use of "imaginative listening" (p. 64), within "dialogal interviews" (p. 64).

Colaizzi believes phenomenological research is the bedrock for subsequent clinical understanding and theoretical formulations because the nature of the phenomenon is retained through the research. The use of a phenomenological methodology to deal with a clinical phenomenon seems quite natural since the methodology in many ways parallels the clinical technique used by many therapists. It attempts to remain faithful to and preserve all aspects of the data by adapting itself to the phenomenon. Colaizzi (1978) supports this orientation to the data, stating that "each particular psychological phenomenon, in conjunction with the particular aims and objectives of a particular researcher, evokes a particular descriptive method" (p. 53).

One of the reasons for using a phenomenological methodology in this research involves the need to fully access and retain the rich clinical experience of therapists. Another reason involves the nature of regression, which is a complex phenomenon with many facets which have remained historically ambiguous and poorly understood. The phenomenological methodology provides a means of achieving the clinical richness of the case study while also allowing for a more detailed and

deeper understanding of regression through an analysis and integration of the experiences of a number of therapists.

Subjects

Eight therapists were used as subjects or co-participants in the research. They were practicing clinicians who expressed a familiarity with and understanding of regression within the treatment process. They all acknowledged experience with at least two types of regression which were either beneficial (benign) or counter-therapeutic (malignant) to the treatment process. This was based on experience with patients within an outpatient treatment setting. Experience with patients who were overtly functionally regressed at the start of treatment, as is often the case in an inpatient treatment setting, was not sufficient. There were no criteria for the depth or degree of regression which the therapists observed other than the simple fact that the patient had regressed relative to their level of functioning at the outset of the therapy.

The therapists also had to have experiences in using regression as a treatment tool with some of their patients. They were not selected on the basis of theoretical orientation, although it was anticipated that most of the therapists would have some form of psychoanalytic perspective. The theoretical orientation, type of clinical training, and other related descriptive characteristics of the therapists was obtained through the use of a subject questionnaire. This is presented in Appendix A. The data from the questionnaire is reported in Table 1.

TABLE 1

DESCRIPTIVE CHARACTERISTICS OF THE THERAPISTS
(N = 8)

	Number of Therapists
Clinical Training/Degree:	
Clinical Psychology/Ph.D.	7
Psychiatry/M.D.	1
(All males)	
Years Doing Therapy Since Obtaining Degree:	
06-10	2
11-15	0
16-20	3
21-25	0
25-30	2
31-35	1
(Mean = 19.9)	
Years Working with Regressed Patients:	
06-10	1
11-15	0
16-20	4
21-25	0
25-30	3
31-35	0
(Mean = 20)	
Theoretical/Clinical Orientation:	
Eclectic	1
Psychoanalytic	3
Psychoanalytic-Object Relations-Ego Psychology	1
Object Relations	1
Object Relations-Analytic	1
Self Psychology-Object Relations	1

In addition to the criteria cited, the therapists were expected to have a minimum of seven years of experience in doing psychotherapy since the completion of their clinical training (i.e. clinical psychology or psychiatric training), and at least seven years of experience in working with regressed patients.

The Subject's Involvement

The time involvement for each subject was approximately two and a half to three hours. This was divided between two components. The first component involved an interview of approximately one and a half hours, in which the researcher questioned the subject on their experiences with regressed patients. The interview was recorded on audio-tape and later transcribed verbatim.

After the subsequent phenomenological reduction process had rendered the transcripts into general thematic categories, the reduced and reorganized transcripts were then returned to each subject. The task here was for the subjects to review the transcripts and provide feedback on whether the reductions had remained faithful to their experience of regressive phenomena. Follow-up comments, corrections, and elaborations were requested through this procedure.

Issues of a Representative Sample

As a phenomenological investigation, Colaizzi (1978) states that the criteria for being a subject is "experience with the investigated topic and articulateness" (p. 58). The criteria stated earlier were used to establish that each therapist had experience with regressed patients in a manner which was pertinent to this research.

The selection of subjects for the research was neither random, nor representative of a broad cross-section of therapists due to the limited number of therapists who meet the criteria for inclusion. It would not have been economically feasible, either in terms of time or money, to randomly select from all therapists and then assess their respective experiences with regressed patients, since this would have provided a hit or miss approach to the phenomenon being examined.

Since the population of therapists who met the criteria for the study was limited, it was difficult to designate a demographically and statistically diverse pool from which they could be drawn. Therefore, the subject selection process was, of necessity, selective and directed by the researcher. It was based on the researcher's contacts with therapists who were familiar with the two types of regressive phenomena, and on referrals by these therapists. Since the research was intended to look at this population specifically, this does constitute a biased sample, given Colaizzi's criteria.

Issues of a Control Group

Phenomenological research does not use control groups in the manner of traditional research. Since no formal manipulation or pretest, post-test design is used, where a treatment has been applied, there is no need to establish a group of control subjects in order to measure the effects of an experimental manipulation.

In this research, natural controls can be identified which serve to establish the validity of the data. The process of comparing the themes derived from each subject's protocol provides one means of

control. Where there is uniformity and agreement in the themes across subjects, there is a greater probability that the subject pool is representative of other therapists' experiences with regression. Any similarities in the themes can be attributed to the studied area, given the varied orientations of the therapists. The validity of the results are also reflected in the points of convergence between the experiences of the therapists in this research and the experiences of therapists within the literature.

The Interview Process

The structure and process of the interviews was developed by the researcher, based on his experiences and readings on regressive phenomena, and his understanding of the phenomenological methodology. The interview process was subsequently refined, based on input from other therapists and colleagues familiar with both the research methodology and the topic area. This resulted in a detailed list of questions which were used to focus the interviews. A copy of the questions is presented in Appendix B.

Format for Initial Contact

Direct verbal contact was made with all subjects, in some cases after an initial written contact, in order to solicit their involvement in the research. Twelve potential subjects were contacted, with eight agreeing to participate in the research. A copy of the initial contact letter is presented in Appendix C. Upon agreeing to participate in the research, each subject was informed of the nature of the research, the

time investment required, and the time schedule for following through on the interview and feedback procedure. The subjects were also informed that they would receive a copy of the informed consent form, the question outline, and the subject questionnaire about a week prior to the interview. It was anticipated that the therapists would use the interview questions to focus their thinking on the phenomenon. At the same time, they were also told that the questions were not intended to preclude their own structuring of the topic, or to exclude any unaddressed areas they deemed relevant.

Interview Questions

The interview questions were directed at three general areas of inquiry for both benign and malignant regression. The areas of inquiry are descriptions, determinants, and explanations, respectively. The list of interview questions presents these three areas in terms of general questions, with subsequent follow-up questions for further exploration or clarification. Thus the general questions provided three focal points for the interview.

These areas of inquiry were developed by the researcher in order to access aspects of the phenomenon relevant to the research. Thus, they reflect the researcher's presuppositions or preconceived beliefs on what is relevant. However, they are also consistent with the fundamental process which therapists use in working with patients.

In this process, the therapist attends to various aspects of the patient, in terms of behavior, mental status, etc. (descriptions), identifies the process of what is going on and possible precipitants

(determinants), and then develops informal hypotheses about why this is happening (explanations). This is an ongoing process which serves to direct the course of the therapy from moment to moment. This very basic assessment process can also be seen in everyday transactions between people.

The therapists were told that the question outline was intended as a sort of exoskeletal structure for the interview which provided an initial focus. With this structure as the starting point, they were encouraged to describe, integrate, or differentiate their experiences with benign and malignant regression in whatever manner seemed most suitable and appropriate for them. It was anticipated that this "exoskeletal" structure would facilitate a rapid and focused immersion in the topic area, while allowing for the expression and preservation of each therapist's unique experience.

Buddenhagen (1984), in his research on the experiences of cancer patients, also organized his research questions on an a priori basis, into sections or units. He arrived at four phenomenological categories, with one category having two subdivisions. He provided a copy of the "five section questionnaire" (p.32) to each of his subjects prior to their interview. The procedure used in this research parallels the approach used by Buddenhagen.

In the final analysis, the validity of using predetermined categories rests within the therapists' acceptance of the categories. Both within the interviews, and through the subsequent feedback procedure, all of the therapists accepted the categories. None of them

indicated any questions, concerns, or doubts about the validity of the categories, even when directly asked to do so.

The Interview

The interviews were carried out by the researcher, in person with each subject, and were audio-tape recorded on 90 minute cassettes. Prior to beginning the interviews, signed informed consent statements were obtained from each subject, as well as subject questionnaires. A copy of the informed consent statement is presented in Appendix D.

To begin each interview, the researcher read "General Question I" directly from the list of interview questions. The discussion then followed the direction chosen by the therapist, with follow-up questions by the researcher to the content which was presented. When the first question area seemed to be well covered, and a point of diminishing returns appeared to be reached, General Questions II and then III were presented and explored, utilizing the same format.

Following each general question, the therapists were allowed to respond in any manner they chose, and often this involved their addressing content from other areas. Consequently, follow-up questions were also used to insure that the three question areas were adequately addressed by each therapist.

The interviews were focused in two ways. First, through the structure of the question outline presented to each therapist prior to the interviews; and secondly, through the questions within each interview. Given the focusing by the researcher, each therapist still imposed their own unique structure and process on the interview. This

was evident in comparing the transcripts in terms of the variety of ways the therapists chose to order, present, and synthesize their experiences of regressive phenomena.

Justification for the structured interview. The interviews followed the general format used in other phenomenological research. The structured interview approach is consistent with the approach used by Buddenhagen (1984) as indicated earlier. In general, the interview process attempts to provide a structure which will allow the subject to focus on their subjective and personal experiences. Barrell (1985) states that in a phenomenological interview,

> ... the researcher guides the subject towards certain topic areas but the subject chooses which specific past experiences to talk about. In all, the research context is constructed while keeping in mind that it is the situation as experienced by the subject rather than experimental conditions imposed by the investigator which constitutes the lived situation (p. 5).

The structured interview procedure used in this research is also similar to the procedures outlined by Bailey (1978) and Sellitz, Wrightsman, and Cook (1976) for a focused interview. While intended for use in a formal content analysis, their procedure lends itself very well to a phenomenological analysis, illustrating a point of convergence between traditional and phenomenological research methods. Sellitz et. al. state that " ... the interview is focused on the subjective experiences of persons exposed to the pre-analyzed situation in an effort to ascertain their definitions of the situation" (p. 319).

Data Collection

The data collection process initially involved audio-tape recording the interviews with each therapist. Each recorded interview was then entirely transcribed into a text. While the completed transcripts suffered a degree of data loss, since the therapists' physical gestures, expressions, and intonation could not be fully captured in a written document, they still served as rich sources of data for the research. The full transcripts were used as the data base for all subsequent analyses and reductions.

Phenomenological Data Analysis/Reduction Process

The phenomenological data analysis generally followed the procedure which Colaizzi (1978) has outlined in some detail. It also drew from the writings of Giorgi (1975) and the methodology used by Buddenhagen (1984) in his research. Thus, the analysis followed general and established guidelines for phenomenological research, but still manifested its own distinctive character in order to capture each of the therapists' experiences of regression in the most meaningful manner.

The analysis process involved a multi-step procedure for categorizing the data. It took the raw data contained within each therapist's interview transcript and rendered it, in its final form, into units which were meaningful to the research. The data within each unit or category constitute the results of this analysis. These relatively large units of data were subsequently subjected to a finer analysis within the Results section. This approach to the results has

been employed by other researchers, including Ashworth (1985), Hannush (1985), and Mook (1985).

Researcher's Preconceived Beliefs

Since the researcher was solely responsible for performing the data analysis, it is important to initially address the researcher's preconceived beliefs which entered into the process. Since these beliefs or assumptions, in the form of implicit hypotheses about regressive phenomena, cannot be dismissed or controlled, they need to be stated so that any potential influence is evident. Within this research, they have already been stated and elaborated at the end of the literature review, in the researcher's hypothesis about the factors leading to the emergence of a benign versus a malignant regression.

The formal identification of any presuppositions or preconceived beliefs is a standard procedure in phenomenological research. It is identified by Barrell (1985) as "bracketing [which] refers to being aware of one's assumptions or being without assumptions" (p. 7). This procedure serves to formalize the researcher's preexisting beliefs, which cannot be formally controlled nor completely eliminated.

Initial Analysis and Reduction

In beginning the data analysis, each transcript or protocol was read a minimum of four times in order to develop some familiarity and intimacy with it. This intimacy reflected a degree of understanding which allowed the protocol to make sense to the researcher as a descriptive document about one therapist's experiences with regressed

patients. The goal was to come to know the phenomenon in a manner which would closely parallel how the therapist knew that phenomenon.

Once this familiarity was established, the second step was to return to each protocol and identify statements salient to the description and understanding of regressive phenomena. The statements varied in length from several words to several paragraphs but, in all cases, retained the language and style of the subject. Colaizzi (1978) describes this step simply as the "... extracting of significant statements" (p. 59). This represents the first level of data analysis and reduction and involved three specific steps or components, drawing in part on the research of Buddenhagen (1984) and presented below:

A) The condensing of longer elaborations or descriptions to their essential elements, and providing summary statements where necessary.

B) The removal of statements which repeated earlier statements.

C) The removal of statements not relevant or related to the study.

This procedure resulted in transcripts which contained focused and condensed statements on regressive phenomena. Due to the need to retain the subtly and complexity of the therapists' experiences, the transcripts still represented large units of data.

Second Analysis and Reduction

The next step involved moving into more subjective and creative areas of investigation. Colaizzi (1978) states that this requires that the researcher attempt to "... leap from what his subjects say to what

they mean ... to spell out the meaning of each significant statement, known as formulating meanings" (p. 59).

Spelling out the meaning of each significant statement is not done in a conceptual manner, however, but in a more literal and concrete manner. The procedure is outlined by Buddenhagen (1984) who states that "this is done by grouping ideas together ... into groups of statements that seem to concern the same general theme" (p. 43). The process of creating thematic units from a unitary document required moving to another level of organization while remaining faithful to and connected with the original transcripts.

The process of "formulating meanings" attempts to cluster statements which represent a thematic unity, while insuring that the subject's descriptive statements still speak for themselves in their original language. Giorgi (1975) states that in this step "one tries to state as simply as possible the theme that dominates the natural unit with the same attitude that defined the units" (p. 87). Colaizzi (1978) also states that the goal is to "... discover and illuminate those meanings hidden in the various contexts and horizons of the investigated phenomenon which are announced in the original protocols" (p. 59). For each protocol this results in clusters of statements which have a natural cohesiveness around a specific theme. Each cluster is then given a label which reflects its meaning.

This process was performed in two stages. The first stage was determined by the fact that two forms of regression were addressed in the interviews with each therapist. Thus, two broad thematic clusters

emerged, within every protocol, reflecting the benign and malignant forms of regression, respectively.

The analysis also revealed a third, unanticipated thematic cluster which was labeled "regression in general." This category, however, did not reflect another distinct type of regression, paralleling the benign and malignant forms. It represented a general category containing data which addressed both types of regression as a unitary phenomenon, or data which simply could not be categorized under one or the other form of regression.

Each therapist's interview was subsequently reorganized into the three themes or categories. This involved assigning statements pertaining to each type of regression to their respective categories. This was a demanding, tedious, and generally difficult process. In some cases, the therapists' statements captured important aspects of each type of regression within a single phrase or sentence. In these cases, the statements were assigned to all the relevant categories.

The second stage in the process was determined by the organizational structure provided through the three general questions presented to each therapist. Thus, three broad thematic clusters again emerged in every protocol, reflecting descriptions, determinants, and explanations for each type of regression. Following the process used in the first stage, the data within each of the three existing categories were divided and clustered into three additional categories. This was done for each protocol.

In general, thematic units in the protocol were identifiable based on shifts from one content or topic theme to another, and therefore

reflected natural units. Since the interviews were structured through the use of questions by the researcher, the thematic units were also demarcated by questions in many cases.

After this clustering and reorganization was completed, it was necessary to return to the procedures used in the first step of the reduction process, in order to remove any redundant or unnecessary words, statements or phrases within each category for each protocol. The statements within the categories were also reorganized in order to group the contents together in a meaningful sequence.

The process in this step resulted in nine general categories or thematic units, forming a 3 X 3 matrix. One dimension reflected the three categories of regression: benign, malignant, and regression in general. The other dimension involved the three areas of inquiry: descriptions, determinants, and explanations. For example, three of the categories involved descriptions, determinants, and explanations for benign regression. The resulting thematic clusters for each protocol were used as the data base for the next step in the process. One of the reduced protocols, which provides an example of the results of the second analysis and reduction procedure, is presented in Appendix E.

As a measure of the validity and inclusiveness of the thematic clusters, they were compared with the original transcripts to see if there was any omission or inappropriate introduction of themes. The validity of these categories was also established through the subsequent feedback procedure.

Feedback Procedure

Prior to initiating the last step in the analysis and reduction process, each reduced and categorized protocol was returned to the respective therapists for feedback. The protocols in this procedure were each reduced and clustered according to the steps in the first and second analysis and reduction process. Thus, each therapist was asked for feedback on protocols that had been clustered into nine general categories. The feedback was achieved through a direct exchange with the therapists, or by mail.

Each therapist received a copy of their reduced protocol, instructions on what to do with it, the original list of interview questions, and an audio-tape cassette. A copy of the instructions for this procedure is provided in Appendix F. The feedback procedure involved asking each therapist if the reduced transcript had remained faithful to their experiences with regressed patients.

As part of the procedure, each therapist was asked to indicate whether the reduced transcript had departed from their original presentation. They were asked to restate their experience in cases where it might have been misrepresented. They were also asked to indicate if the thematic reorganization of their interview was meaningful and appropriate, and whether their statements had been clustered with the right categories. In addition, the therapists were asked if they had any additional experiences, thoughts, or examples to provide on regression. Finally, they were asked for feedback on the categories used to organize their interview, and specifically if it was a valid means of organization.

The feedback. The therapists were given two methods for providing their feedback. One was direct and involved written or audio-taped responses. The other involved letting an established deadline pass which indicated that they fully accepted the reduced and categorized protocols as valid, with no need for revision.

Of the eight therapists, five chose to respond directly to the researcher. Of the five, three of the therapists indicated that they found their reduced and analyzed interviews fully valid, with no need for alteration. The other two therapists provided feedback on minor changes they felt were needed in their protocols. The alterations reflected either a minor shift in the therapist's views or a change in the wording of a specific statement. Thus, the feedback was directed at correcting what they presented in the initial interview. These changes were subsequently integrated into their protocols before the next step in the analysis.

For all five therapists, there were no requests made to reassign data to different categories. There were also no indications that the categories were invalid, inappropriate, or unacceptable in any way. The other three therapists chose to let the deadline pass as a communication of these same points. Thus, there was uniform acceptance of the reduced and categorized protocols.

The feedback procedure as a validity measure. The use of the feedback procedure insured that the reduced transcripts were faithful and valid representations of each therapist's experiences. It also served as a validity check on the data reduction process. Each

therapist's acceptance of their protocol served to validate both the reduction process and the categories which were developed.

The categories, as indicated, were the outcome of the researcher's focus on specific question areas in relation to specific types of regression. This differs from the procedure employed in some phenomenological research where the categories appear to emerge more independently from the data. However, the uniform acceptance of these categories by the therapists validates that they are meaningful and representative of the data. Thus, they fulfill the goal of the second analysis and reduction procedure, which is to group ideas together into statements that involve and reflect the same general theme.

Third Analysis and Reduction

The final step in this process brings the analysis to the level of examining and evaluating all of the protocols. This involved making comparisons across protocols and subjects in order to create more fundamental and all-inclusive themes and categories which were common to all of the subjects' protocols (Colaizzi, 1978). The goal of this process was to allow any additional general categories to emerge from the data.

In comparing all the protocols, a more fundamental thematic organization and categorization emerged which transcended the initial nine categories. These fundamental categories reflected a natural cohesiveness around three perspectives which the therapists assumed in relation to their experiences. These perspectives, and the resulting categories, reflect the therapists' intuitive structuring of the data,

based on the nature of their experiences with the phenomenon. The categories were therefore labeled: the therapist's experiences of the patient; the therapist's self-experiences; and the therapist's experiences of the relationship with the patient.

The therapist's experiences of the patient involve those experiences which reflect the role of the therapist as a relatively detached observer. These experiences focus on the patient as a separate and discrete individual, independent of the surrounding context. Straightforward descriptions of the patient's mental status would be an example of the data categorized under this theme.

The therapist's self-experiences involve self reports, or observations on other therapists, which make overt the internal world of the therapist. Very often, this is set in a context which involves their personal response to the patient and the treatment process. An example of this theme would be a therapist's comments on how they felt when a patient was in a malignant regression.

The therapist's experiences of the relationship with the patient addresses the broader context of the patient's regression. Here, the intricate and often reciprocal process between the patient and the therapist is recognized. The experiences of the relationship clearly reflect the therapist's role as an active participant observer in the patient's regression. The effects on the patient of a technical error by the therapist is an example of the data which would be categorized within this theme.

These categories were subsequently used to organize the data within the original nine categories. This lead to 27 categories (3X9)

or themes. The data within each of the nine initial categories were divided and reorganized into the three fundamental categories. For example, one category involves the therapist's experiences of the relationship with the patient in terms of their descriptions of the relationship in a benign regression.

The data within each of these 27 categories or themes represent the results of the analysis and reduction process. The large number of categories allows for a very focused description and analysis of the results. The organization of the 27 categories is presented in the Results section.

Use of the Reduced and Categorized Data

Once the phenomenological analysis and reduction procedure was completed, the final step was to analyze and integrate the data contained within the 27 categories for each protocol. The goal here was to produce an exhaustive description and in-depth understanding of regression. This analysis and integration is presented in the Results section.

Reliability Measures for The Analysis/Reduction Process

Since the data analysis process was performed by the researcher alone, it was necessary to establish a reliability measure to insure that the derived data could be replicated by other researchers. This is an important measure for phenomenological research, given the nature of the data reduction process. However, the requirements differ from those used in more traditional research since it is not simply the

procedures which need to be similar but the attitude taken by the researcher towards the phenomenon. Once another researcher is able to assume a similar attitude towards the phenomenon, they should be able to arrive at the same results (Barrell, 1985).

Central to establishing reliability in phenomenological research is whether or not another researcher can assume the same orientation or perspective on the data which the original researcher had in conducting the research. Simply stated, approaching the data with the same perspective should result in the same data becoming relevant for different researchers, when the same procedures are followed. It was assumed that once the data reduction steps and the perspective or attitude of the researcher were communicated to another researcher, the same results would be obtained.

In this research, this process parallels the researcher's initial efforts to assume the attitude of each therapist in order to faithfully capture their experiences. The measure of the researcher's success in this endeavor was provided through the feedback procedure.

Procedure for Establishing Reliability

In order to establish the reliability of the reduction process a reliability rater was asked to go through the same procedures which the researcher used with each individual protocol. Originally, two raters were enlisted and agreed to serve in this role for the research. However, one of the raters was unable to maintain their involvement for personal reasons and had to withdraw. Thus only one rater was used.

The reliability procedure involved the rater going through the first two data analyses and reductions with one protocol. Other researchers have used a similar reliability measure with one rater in conducting phenomenological research (Buddenhagen, 1984).

In order for the rater to follow the same process with the same attitude of the researcher, a scoring manual was developed which outlined the data reduction process and provided concrete examples. A copy of the scoring manual is presented in Appendix G. The reliability rater used in the research had the same clinical psychology training background as the researcher, as well as some familiarity with regression. This helped in their assuming a similar attitude towards the data. The rater was not familiar with the phenomenological methodology, however.

Upon completion, the rater's reduced and analyzed protocol was compared with the researcher's protocol. Reliability was assessed through a measure of occurrence-nonoccurrence agreement based on the number of statements which were assigned to the same categories in the two protocols. This was used to generate a percentage agreement statistic. In order to correct for chance-expected agreement, and establish a more stringent reliability measure, the Kappa Coefficient was also computed (Fleiss, 1981).

The Reliability of the Process

The percentage of interrater agreement obtained was 91%. The Kappa Coefficient obtained was .51. Acceptable values for Kappa range from .40, which represents fair agreement, to .75 which represents good

agreement beyond chance. Coefficients above .75 represent excellent interrater agreement (Fleiss, 1981). Thus, the data reduction and analysis process is fairly reliable given the criteria of the Kappa statistic.

CHAPTER IV

RESULTS

Introduction

The wealth of data on regressive phenomena contained in eight therapist interviews is overwhelming, not simply by virtue of its sheer magnitude, which is considerable, but more significantly by virtue of its intricate, and often subtle, richness. The results of the phenomenological analysis and reduction process yielded 27 categories containing a great deal of data on therapists' experiences of regressed patients.

It became evident in examining the results within these categories that the therapists' experiences of regression reflected a highly complex and multiply interactive phenomenon with many subtle aspects which each called for some means of illumination. These fine yet discreet facets each needed to be identified in order to create a meaningful mosaic of the whole.

In order to obtain a more complete and integrated understanding of the phenomenon it was therefore necessary to let the therapists' experiences dominate the results. Consequently, a lengthy and exhaustive analysis of the results was undertaken and completed. This analysis organizes and synthesizes all of the results from all of the therapists' protocols. The full analysis is available from the author upon request. Its sheer length precludes its insertion here. The organization of this analysis is presented in Table 2.

TABLE 2

ORGANIZATION OF THE ANALYSIS OF THE RESULTS

Categories	Therapist's Experiences of the Patient	Therapist's Self-Experiences	Therapist's Experience of the Relationship with the Patient
		Types of Regression	
Descriptions	Benign Malignant In General	Benign Malignant In General	Benign Malignant In General
Determinants	Benign Malignant In General	Benign Malignant In General	Benign Malignant In General
Explanations	Benign Malignant In General	Benign Malignant In General	Benign Malignant In General

This organization allowed for a highly focused and detailed analysis of all the therapists' experiences. This approach is consistent with Colaizzi's (1978) position that the results should present an "... exhaustive description of the investigated topic" (p. 61). The analysis used here was dictated by the unique nature of the results. Thus, it is also consistent with a basic tenet of the phenomenological approach, that the subject matter determines the methods used to study the subject. This is directed at allowing the experience to speak for itself (Colaizzi, 1978).

Including all the data from the reduced protocols in the analysis of the results allows other therapists, as well as other researchers, to see the subtle shades of meaning and significance in the data. In the process it also allows the reader to extract additional or different meanings and conclusions from the data by having it available in this manner.

A highly detailed distillation and integration of the analysis of the results is presented in this section. It is referred to as the Summary Analysis of the Results. It includes selective illustrative examples drawn from the full analysis of the results.

This approach to presenting the results is consistent with established phenomenological research methods (Hannush, 1985; Mook, 1985; Polyzoi, 1985). For example, Ashworth (1985) employed a similar analysis of interview data, as well as an integration of that analysis within the results section. In essence, presenting the results in this manner allows the reader to follow the process which the researcher employed in making the results meaningful.

In the process of collecting the data in the interviews, it became evident that each therapist set their own course and direction, in terms of the experiences they chose to present, despite the structure provided by the initial interview questions. In a similar manner, the results assume a life and direction of their own despite the initial focus and structure imposed by the many categories in the analysis of the results. This should also become evident to the reader as they explore the results.

Summary Analysis of the Results

The results in the summary are presented within 9 categories which represent a 3 X 3 matrix. These are the same categories which were generated in the analysis and reduction process, with the exception of the descriptions, determinants, and explanations categories. The data from these three categories are integrated within the 9 categories rather than formally identified and separated.

The three general categories which describe the therapists' experiences are used as the primary organizational elements for the summary analysis. They reflect the therapist's experiences of the patient, the therapist's self-experiences, and the therapist's experiences of the relationship with the patient.

Within these three general organizational categories, the data are organized into three specific categories in terms of the type of regression: benign, malignant, and regression in general. Table 3 presents the organization of the summary analysis of the results. Across the 9 categories there is some repetition evident in content and themes. This reflects the many apparent similarities between the various manifestations of regressive phenomena.

The Therapist's Experiences of the Patient: Benign Regression

Therapists indicated that patients who were entering or already in a benign regression displayed a variety of characteristics and behaviors. None of these behaviors or characteristics were specific to regression, however, and therefore could not be used as sole indicators of the presence of a regression or whether it was benign or malignant.

In order to make such an evaluation, the patient's current functioning had to be considered within the broader context of the therapy process and their previous level and style of functioning.

TABLE 3

ORGANIZATION OF THE SUMMARY ANALYSIS OF THE RESULTS

	Therapist's Experiences of the Patient	Therapist's Self-Experiences	Therapist's Experience of the Relationship with the Patient
Types of Regression	Benign	Benign	Benign
	Malignant	Malignant	Malignant
	Regression in General	Regression in General	Regression in General

In a general and discernible sense, the patient's entrance into a benign regression is usually marked by some observable shift in their functioning, or in the content they present within the context of the therapy. This can assume many forms, including the emergence of more affect, the relinquishing of defenses, and significant dreams emerging.

In a benign regression, the shifts in the patient's established mode of functioning within the sessions usually do not result in any disruptions in functioning outside of the therapy. The changes most often involve an emergence of earlier modes of functioning, with increases in affective expressions, including affective distress. The

types of shifts which some patients present is illustrated in the following quote:

> There was a deterioration in cognition in terms of language, form of language. They would revert to a vernacular that was younger than what they were at, at that particular time. Occasionally, grammar would slip, accents would come back that weren't there when they were in a non-regressed state. There was frequently tearfulness. There was a real and palpable statement about how they couldn't go on, couldn't function, and couldn't deal with the vicissitudes of their life outside of the office. When, in fact, they left each time and went out and did their job.

The one recurring element which consistently identifies the emergence of a benign regression involves shifts in the patient's mental status from more reality oriented, secondary process functioning, towards more diffuse, primary process functioning. This involves a controlled and integrated immersion in primary process experiences and functioning.

This is often accompanied by the patient's experience of a time distortion. Very often patients report that time has sped up during the session. This reflects a movement away from a secondary process, reality orientation, towards primary process modes of functioning and experiencing. Some of the primary process experiences which patients present in a benign regression are conveyed in the following excerpt:

> ... [the patient] can roam internally in their fantasies and explore what's going on and what they see and what they think about things. There can be a reduction in critical thinking, and a reduction in secondary thought process.... The person is playing around with ideas, musing with ideas that often aren't critically correct. Its like primary process without the fear. Often ... patient's as they come out of it towards the end of the session, will indicate their surprise at how rapidly the time of the session passed. So ... there seems to be a speed up of time. And other times, in a playful way, they will talk about perceptual distortions. They'll talk about colors and shapes in such a way that it has a very fluid quality to it.

> They'll go through various perceptual changes about things, and as they do it they don't seem particularly alarmed about it. They're sort of playing with the changes in perceptions.

It is important to note that while primary process functioning emerges, secondary process functioning is also present, but it no longer dominates the patient's functioning. Thus the two modes of functioning coexist in varying degrees.

Parallels can be drawn between regression and the experience of dreaming. The dream reflects an organized immersion in primary process experiences, where there are controls to keep it from becoming overwhelming and disorganizing. Thus, benign regression is a clinical application of a controlled immersion in primary process. This is conveyed in the following passage:

> I take as my model the idea that all of us sink into a benign regression every time we go to sleep. ... everyone has the experience of benign regression constantly. Its the sense ... that it is in control. ... that it is a normal operation ... a normal experience. People take it for granted.... But, they report a lot of the phenomena of benign regression when ... they wake up and start talking about their dreams, this account of the excursion into primary process.

As a result of the primary process and affective nature of many of the patient's experiences in a benign regression, it is often difficult for them to organize and verbalize these experiences. Therapists identified these experiences as preverbal, or affective memories and experiences. As a result, they can contribute to some initial confusion and anxiety for the patient if they are not informed that a regression is emerging. The shift into primary process also contributes to a non-focal, diffuse, or internally preoccupied quality

for most patients. The content in a benign regression often reflects earlier issues from the patient's developmental past.

Therapists report a great deal of variability between patients in terms of what they present within a benign regression. This includes differences between patients in the depth of the regression. Despite the variability, the mental status descriptions of the patients tend to characterize two general types of benign regression. There are patients for whom the regression appears to be an extremely blissful and soothing experience. These patients can fall asleep in sessions and awaken feeling refreshed and euphoric. They can also be quite playful in dealing with primary process experiences, accepting the changes in functioning, cognition, and perception as if they were normal. There is a general absence of fear or anxiety for these patients. This type of benign regression was illustrated earlier in the second quote.

At the other extreme, there are benign regressions in which the patient's experience is rather dreadful, and full of fear and anxiety. Their functioning and mental status is tumultuous, with temporary losses in specific ego functions at times. The patient's affective state is far from blissful and is characterized by distress and a sense of being emotionally under siege. Thus, a benign regression is not, by definition, always benign in terms of the patient's emotional state and mental status. This type of benign regression is described in the following excerpt:

> ... [patients] will complain to you about intense affective upset and extreme high anxiety and a lot of ideational, somato-affective internal type symptoms where they are terribly

> discomforted and they feel very scared, and intensely worried about going crazy, and just feeling really under siege emotionally.

A central factor which makes both the blissful and turbulent types of regression benign is the maintenance of integration and control. Where controls are available to keep the patient's general functioning adaptive, and the treatment process going, the regression is benign. These controls allow for the primary process experiences, and the intense affects associated with them, to be experienced without completely inundating and overwhelming the patient so that there is a breakdown experience and decompensation. There is no decompensation as long as the regression is benign. The importance of controls in a benign regression is conveyed in the following two quotes:

> The most broad distinction you would make is out of control versus not out of control [comparing malignant to benign regression respectively]. The therapeutic regression I see as a more controlled phenomenon.

> ... the reason that its benign is that it has a sense of controlled affect. ... Now, benign fades into pathological around such variables as intensity, control or uncontrol, and the affective response to the experience of it.

The controls serve to maintain the patient's functioning, both within and outside of the therapy sessions. A loss of controls and disintegration in functioning outside of treatment is often seen as an indicator that the regression may be turning malignant. Temporary losses of control, reflecting deficits in specific ego functions, often occur in a benign regression, however. For example, a patient's judgment, impulse control, or perceptions may be briefly impaired. Therefore, the therapist must make an ongoing assessment of the patient's functioning in order to determine whether the losses in

control are temporary and part of the process of a benign regression, or whether they reflect the emergence of a malignant process.

Most of the therapists indicated that a benign regression is a natural outcome and part of the therapeutic process. Whether or not it occurs for a particular patient, and the way in which it occurs, is primarily the result of two general and interactive factors. One factor involves the patient's underlying character structure and ego functioning. As a general rule, structurally more intact patients manifest greater control, while structurally less intact patients manifest less control in a regression.

As a result, neurotic or structurally more intact patients generally have more organized and less turbulent regressions. Characterological or structurally less intact patients are seen as having more agitated regressions. The latter group therefore requires more direct support in maintaining the regression, and usually more extensive work in building controls and structures prior to the regression. Without the necessary structure, a sustained benign regression is not possible. The importance of character structure is conveyed in the following excerpt:

> It seems that a patient's character structure and defenses always play a major part in the variability among patient's with regard to their experience of regression. I believe that the manner of expression, unfolding, and timing of the experience of regression are precisely related to characterological aspects and style.

The patient's capacity to enter into and maintain a benign regression is also determined by the nature of their relationship with the therapist. This includes the patient's acceptance of the

therapist's capacity to manage the regression. In the case of the structurally less intact patient, the therapist's capacity to manage the patient's affective distress, and limitations in maintaining control, is critical to whether or not the patient can have a benign regression.

For this to occur, the therapeutic relationship must reflect the development of a solid alliance and rapport. This requires a capacity for trust and attachment by both the patient and the therapist. These factors are elaborated in the section on the therapist's experiences of the relationship with the patient.

The patient must also have some capacity for insight, and a belief that the therapeutic process can bring about change. In this process the patient has to accept an active role in terms of accepting and wanting the regression and then making therapeutic use of it. A benign regression, given all other factors, is still something that a patient must agree to and want. It is an event which only occurs when the patient is willing to give their consent. The importance of the relationship and the patient's acceptance of the regression is conveyed in the following quote:

> First of all, you have to have a stable attachment. That there's a working alliance between you and the patient. Then there has to be a psychological wish on the part of the patient to return to the scene of the crime. Now some people have this wish and others don't. If they don't have that wish, you do not have benign regression. It's not something that you as a therapist can inject into the situation. I mean, either the patient is interested in moving in that direction and will carry you there or they're not.

Therefore, a benign regression is an internal, psychological phenomenon, and not simply a response to a mix of specific factors.

Within the agreement to enter a benign regression, it is necessary for the patient to believe that control can be maintained, and that the primary process experiences and potentially distressing affects can be contained within a tolerable level.

Based on the patient's own intuitive assessment of the limits of the control available to them, they generally enter into varying levels of regression. The patient's defensive and characterological style, and degree of relatedness with the therapist also determine the level of the patient's regression. The therapist must make an assessment of these factors in order to help the patient work within their controls.

The therapist also has to determine whether or not a patient is appropriate for a benign regression, based on the various factors already presented. Individuals with severe relational and structural deficits may not be able to sustain the process. The timing and pace of the regression are also factors which the therapist must manage. Paralleling the patient's willingness to accept the regression, it is also important that the therapist be willing to accept and enter into the regression with the patient.

Benign regression was generally conceptualized as a specialized species of a natural everyday phenomena. It was conceptualized as a natural mechanism which allowed for a reworking of the past in the present. It generally emerges out of the therapeutic work, and reflects the patient's natural need to go back to and rework unfinished business in order to improve their current level of adaptive functioning. This reflects a sense of developmental blockage which a patient must rework. This is illustrated in the following excerpt:

> I see it [regression] ... as a natural process. We're talking about a phenomenon that we see everywhere. I don't think its a whole lot different than returning to where you left off. And, you need to fix whatever you need to fix. People, in some fashion, sense that.... there's a natural impulse to do that therapeutically within the individual patient. He knows he needs to get back somewhere. Give him time, stay out of his way, he'll get back there. You get back to where you've been stuck. I think there is something to the notion of a repetition compulsion.... You go back to what you didn't do right the first time.

The therapists indicated that benign regression involves a return to a specific issue or area which needs work, rather than just a return to an earlier developmental level, though both were considered possible. Object relations and narcissistic issues are often reworked in a regression. One therapist described the process as "an emotional regression through time", where the patient returns to previous emotional experiences which need to be reworked.

In order for the reworking process to occur in a benign regression several factors must be present. In a general sense there must be a shifting in the patient's level of consciousness which frees them from the restrictions of conventional secondary process, reality oriented functioning. The patient must be able to accept new experiences and new potentials. Here, the shift in the level of consciousness reflects a shift into primary process modes of functioning.

It is important to note that four of the therapists indicated that primary process should not be automatically equated with primitive levels of functioning. They hypothesized that it reflects another type of functioning and another type of cognitive organization relative to secondary process functioning. It was also offered that primary process may continue to develop along with secondary process, and

therefore plays an important role in everyday functioning. These views are presented in the following passages:

> ... to call primary process primitive, is a disservice. In the same way that it's not a movement back to primitive modes of thought, necessarily.... It's just another level of cognitive organization. And the optimal way of a person working on themselves, even in self analysis, is a flexible integration of secondary and primary process modes of operating.

> ... what we call primary process and what we call secondary process are not in order. I don't think you have primary then you drop it and you start secondary. I think there is a line of development for primary process and a line of development for secondary process, and they both develop in their own way. If you have an overpredominance of either one you can have problems.

The shift into primary process does not reflect a wholesale shift, however, since specific functions or parts of the patient's ego are still available to maintain control and perform the necessary work required by the therapy. Thus, the benign regression is not conceptualized as a complete regression by the ego. It is a partial regression which allows for past experiences, often from early childhood, to be reworked in a controlled manner with the more mature ego of an adult. Along these lines, one therapist indicated the use of a multitrack model to explain that a patient is usually regressed along one line of development, while accessing the unregressed potentials along another line to perform the therapeutic work.

The notion of a partial regression serves to explain why patients can still function relatively well in their everyday lives while in a benign regression. One therapist indicated, however, that emotionally the patient moves toward a constant level or state of regression which is maintained over time during the therapy. The patient is not seen as

emerging completely from the regression at the end of the session. Thus, part of the patient may remain regressed between sessions.

Within the process of shifting into a different level of consciousness, the patient needs to willingly relinquish their more rigid defenses. This process also serves to make more information available to the patient which can then be used to rework past issues. There also needs to be a controlled affective accompaniment to what the patient experiences in the regression, so that it is real for them. A purely cognitive experience is not sufficient.

In terms of the work within the benign regression, there were some theoretical differences between the therapists, in terms of the nature of the process. Five of the therapists saw the process itself as the basis for structural change, with less emphasis on content. The other three therapists saw the regressive process primarily as a vehicle, where the work involved the analysis of the transference phenomena which emerged while the patient was regressed.

There was more uniform agreement, however, on the results of a benign regression. In general, the regression was seen as leading to improvements in the patient's ego functioning which eventually became incorporated into structural changes. This included an increased flexibility in the use of controls, a greater flexibility to access past and primary process experiences and functioning, and improvements in object relations and self-organization. Overall, the benign regression results in a structural change which allows for more adaptive, flexible, and pleasurable functioning by the patient.

All of the therapists indicated that the regression is a necessary part of the treatment process in order for structural change to occur. For them, structural change is not possible without the regressive component. Several of the therapists also overtly conceptualized regression as a natural precursor and complement to the process of progression.

The Therapist's Experiences of the Patient: Malignant Regression

Patients in a malignant regression can present a variety of symptoms, with varying degrees of distress and disorganization. Examples of malignant regression ranged from patients who presented severe disturbances in ego functions, with overt disruptions in the therapeutic alliance and process, to patients who maintained control with no overt disruptions in these areas. Thus, malignant regression is not a simple all or none phenomenon which can be captured within a single descriptive characterization.

One type of malignant regression reported by one therapist involves the patient's immediate distortions in assuming a fused, intimate relationship with the therapist where none exists. Another type of malignant regression involves the subtle operation of projective identification mechanisms which serve to distance and even frighten the therapist. In both cases the patient does not overtly express any distress or loss of control and integration. However, they are subtle and insidious forms of malignant regression which serve to potentially disrupt the therapeutic alliance and process.

Another example was presented of a patient who was in a suspended or constant state of malignant regression. The patient was not completely out of control, but experienced ongoing fears and anxieties which would occasionally erupt into states of terror, with a subsequent disorganization in their functioning. While habitually regressed, this patient did not present like other chronically regressed patients who are usually psychotic and manifest a fragmented personality and deteriorated functioning. This patient was relatively organized but stuck in a malignant regression. The patient was therefore constantly moving in and out of primary process, but not constantly out of control.

These forms of malignant regression differ from the descriptions usually found in the literature. Malignant regression is usually described or characterized as involving an overt loss of controls with a disintegration in ego functions by the patient. This appears to reflect a "standard" type of malignant regression which was indeed also reported by all the therapists. The previous examples illustrate that there are also other forms which a malignant regression can take.

As in the case of the benign regression, there is also a great deal of variability in the symptomatic expressions of patients within the standard or general form of malignant regression. This ranges from severe decompensations and psychosis, with loses in reality testing, judgment and impulse control, to more depressive symptoms. In general, however, this type of malignant regression involves pervasive disturbances in the patient's ego functions and controls, with confusion and affective flooding. Secondary process functioning is

generally severely impaired, with a predominance of primary process experiences. This is often accompanied by fear, panic, and even terror by the patient and usually occurs both within and outside of the therapy. The pervasive and severe aspects of a malignant regression are described in the following passage:

> The patient in a malignant regression is likely to be confused. And ... is probably going to present a moderate, if not severe degree of impairment of reality testing, judgment or both. They may not be psychotic, in the sense of schizophrenic psychotic, but they might have lots of mini psychotic episodes. They may at times be delusional. They may be suffering from dissociative experiences. They may be impulsive or tempted to be impulsive. They may be tempted toward self-destructive kinds of things. They are probably highly agitated ... affectively flooded in one form or another. Having an experience of their existence as in a twilight, in a nightmare.... They're likely to be showing this in their day to day functioning during such a period. The ego, in terms of relinquishing and reinstituting secondary process or ego synthetic functions, in a malignant regression its shot, its not operating much of the time. I'm impressed in malignant regressions with the time perspective distortion. With patients in essence, maybe psychologically in some way, living in a moment that might have actually been like what they experienced at some crucial traumatic period.

This type of malignant regression also involves a distortion of the therapist, who is often experienced as a destructive or malevolent figure. This is usually a result of the patient experiencing some sense of threat in relation to the therapist. In the extreme, this can result in perceptual distortions of the therapist. When the distortions are severe, there appears to be an unconscious reliving experience by the patient, where they respond to the therapist as if they were a significant figure from their past.

The therapists generally reported that the phenomenological experience of the patient in this type of malignant regression appeared

to reflect feelings of helpless and being out of control, with no clear support or structure available to them. This was often accompanied by compelling primitive experiences and terrifying affects. At times this also involved experiences of the world and the therapist as strange or unusual.

The metaphors therapists used for the patient's experience in a malignant regression reflected an Alice in Wonderland quality of falling endlessly, or a nightmare quality of experiencing intense terror in a primary process existence. This quality is captured in the following quote:

> The mounting sense of fearfulness which I associate with being immersed in primary process and you can't get out, you can't escape it. ... The fear reaches panic proportions, and that's when people start doing all sorts of strange things in order to control the fear. When regression becomes pathological, from a clinical point of view, you're looking at someone who, for one reason or another, is having some kind of decompensation of defensive operations and they're not working properly. And people describe this as, "its like falling into a black hole," or "I'm falling endlessly," or "everything is the same," with an enormous sense of dread. When weird and strange things happen, and they're completely unexpected. There is no sense of causality, they just happen. And they have to deal with a sense of annihilation. ... its main characteristic is an enormous amount of fear, panic, dread, terror, the sense of complete impending destruction of the self, of being, of existence.

Many of the examples of a malignant regression cited by the therapists presented patients in a state of paranoia, where they were constantly in terror and vigilant because of fears of being annihilated. This included fears over the loss of boundaries and the potential for merger and the loss of the self. These patients also tended to experience the therapist as attacking them in some way. This is conveyed in the next passage:

> With the malignant regression, usually I see that early in the treatment. The main characteristics are paranoid ... You see a lot of hypervigilance. Sometimes you see a look in their eyes where they get unfocused, get a crazy look in their eye. And definitely a feeling that they're responding to a great deal of internal stimulation. Overall, what I see in that is a lot of fear, projection of very negative power onto me the therapist. Like I'm going to do something bad to them, or I'm trying to control them. And, the more intense this is, the more you do see the going away of ego functions. The person's judgment, even the person's perception begins to get very distorted in the situation. In extreme cases there is an actual physical perceptual distortion of me. Where they think I'm starting to look very menacing or I'm changing the way I'm looking in front of them. And the more that goes on, the more the patient gets very afraid.

Some of the therapists indicated that patients who rapidly enter a malignant regression at the outset of the therapy are generally prone to this as a result of structural factors. The more structurally impaired patients were generally seen as more vulnerable to malignant regressions, which tended to be more severe and pervasive. Thus, the level and extent of the regression can be a function of structural factors.

The more structurally intact patients can also enter a malignant regression, but what they present is relatively less severe, with a greater capacity to reestablish controls and reintegrate independently. Even with the more structurally deficient patients, there is usually a return to a higher level of functioning after the regression. Thus, the process usually does not reflect a shift into a permanent state of malignant regression, though the patient can stay there for extended periods of time.

All patients were seen as potentially at risk to enter into a malignant regression given the proper circumstances. One therapist

indicated how everyone enters and experiences a malignant regression whenever they have a nocturnal nightmare. The nightmare was seen as an example of the terrifying experience of being uncontrollably immersed in primary process experience and flooded with affect. The nightmare usually involves an experience of helplessness in the face of impending doom and destruction while asleep. It reflects a common occurrence of a psychological experience which, in the extreme, is described as the worst experience anyone can have.

All the therapists indicated that there are multiple determinants for a malignant regression which function in an interactive manner. A central and fundamental determinant is the patient's character structure. The structural component is seen as predisposing patients to a malignant regression, but is not a sufficient condition for it to occur. While this factor often contributes to its occurrence at the outset of the therapy, malignant regressions can also occur at any other time.

The therapists cited various factors, include past experiences, genetics, and neurochemistry, which could determine the patient's structural propensity for a malignant regression. The respective roles and degree of interaction between genetic and environmental factors in this process is difficult to determine. The contribution of the patient's past object relations history usually involves the effects of relationships with actively destructive significant figures. The genetic factor, in the extreme, is seen as leading to a schizophrenic condition of total immersion in primary process, and a total destruction of the personality. Here there is virtually no capacity to

reverse the regression. One therapist tied this to the patient's inability to maintain any type of boundaries.

Given these historical and structural factors, there is usually an interplay with factors in the patient's present experience which determine whether or not a malignant regression will occur. This demonstrates the constant interaction between past and present in a malignant regression. The determinant or precipitant which generally leads to a malignant regression involves the patient experiencing some sense or form of threat in the present.

The threat is usually experienced by the patient as fully or partially recapitulating some experience in the past, usually in relation to a threatening or destructive object. This can trigger a kind of automatic response which usually occurs quickly, and is often unresponsive to the broader context or reality of the situation in which it occurs. In this case the malignant regression often runs a specific, predetermined course unless it is reversed in some way. This may reflect the structural component. The patient's automatic response to a sense of threat is presented in the next quote:

> What happens is that something occurs internally that is threatening enough, that promotes a return to a way of handling things that goes way back, it's like a reflex, automatic response. And the threat is severe enough, that you don't have time to reflect on it. And you're going to do whatever you've used or you believed was effective before, and its going to just occur. And I believe pathologic regression is something like that. The threat is severe enough that there isn't time for processing.

Within the therapy process and relationship, some aspect of the transaction with the therapist usually serves to precipitate the malignant regression. This can result from some technical error, or

error in management by the therapist, which the patient experiences as threatening. This potential for precipitating a malignant regression is addressed in detail in the section on the therapist's experiences of the relationship with the patient. The interplay between the patient's structure and the interaction with the therapist is presented in the following passage:

> The primary ego function impairments is what I consider to be the basis for pathological regression. For example, weaknesses or deficits in ego boundaries. ... These weaknesses define or describe a patient's current and probably historical mode of functioning. They're going to occur, to some degree, in any relationship. A therapeutic relationship which fails to recognize the patient's needs for structure and support of ego functions would be the thing that "happens", in therapy. The therapy context, because of its intensity and focus for the patient, could itself be the basis for pathological regression, although it is likely that such regressive forces had been operating previously in the patient's functioning and were probably acutely exacerbated in the face of some recent stress.

Factors external to the therapy can also precipitate a malignant regression. This is usually in the form of some major trauma or stress in the patient's life. In some cases, aspects of the trauma will serve to recapitulate past traumatic experiences. Here the malignant regression is generally a result of the trauma being severe enough to overwhelm the person's control mechanisms and capacity to maintain integration. Thus, everyone is at risk for a malignant regression when the trauma is severe enough.

One therapist offered a sort of formula which would result in any patient entering a malignant regression in the course of the therapy. This involved having the patient in an unstructured situation where they were dealing with primitive and primary process contents, and then removing the controls and stability provided by the therapist through

the relationship. The loss of controls embodied in the relationship with the therapist when the patient is experiencing a lack of structure is seen as precipitating the patient's malignant regression.

Six of the therapists' conceptualized malignant regression as one point along a continuum which included benign regression. Thus, they conceptualized malignant regression as one manifestation of a general and unitary phenomenon.

In the following quote the therapist cites that the major factors which differentiate malignant from benign regression are the extent of threat experienced by the patient in relation to the therapist, and the degree of control which is maintained. In a malignant regression the threat confronts the patient with basic survival issues and the experience of potential disintegration and annihilation. These experiences serve to activate the patient's archaic and automatic response to maintaining survival. When this is activated, the patient tends to lose the relationship with the therapist in an attempt to protect themselves. Here they do not turn to the therapist for help. The therapist states:

> My sense is that they're not discretely different phenomena [benign and malignant regression]. That they're the same phenomena and the differentiator is the extent of threat. The pathologic is an effort to cope with something or to return to the only thing you knew before that you thought had any chance of working, as a way of coping. It occurs too quickly, without thought, too automatically. And I attribute that to the intensity of the threat. When that occurs, the patient's dealing not with conflict, but with survival issues.

In terms of the emergence of primary process content in a malignant regression, it is not seen as problematic in and of itself. The patient's capacity to maintain their controls is considered the

more important factor. Thus, when the patient loses their control mechanisms, for what ever reason, then the primary process material becomes problematic.

In relation to the reintegration of the primary process content, several of the therapists indicated that a malignant regression can become therapeutic and useful if it is eventually integrated into the therapy process. Thus, it does not have to remain malignant. In order for this to occur the patient must have the capacity to reestablish the controls, as well as the willingness to accept and integrate the primary process material into the therapy.

The Therapist's Experiences of the Patient: Regression in General

This category involves regressive phenomena which could not be categorized as either benign or malignant. It also includes general information which might apply to or involve both types of regression. Thus, it is more of a catch all category rather than a specific type of regression.

In some cases, the data in this category were drawn from only one or a few therapists. One therapist specifically indicated that their statements reflected general aspects of regression, which could not be categorized as benign or malignant initially. Nevertheless, the content in this category remains highly consistent with the data for benign and malignant regression.

In the following passage, a regressed patient is described as generally functioning at a more primitive level, with the use of more

primitive defenses and expressions of more primitive concerns. There is also a quality of being potentially out of control:

> ... what we're talking about is more primitive motives being manifested in the behavior, and more primitive adaptational mechanisms. So that, the ego defenses that get employed would tend to be relatively primitive. Less sublimation and more denial, or projection or, splitting or failure to integrate. Phenomenologically, you're talking about a sense of emotional intensity, an urgency, and a sense of lack of control. ... I'm talking about regression in general right now.

As a general phenomenon, there are a broad variety of behaviors and symptoms which make regression elusive and difficult to describe in a definitive manner. One therapist indicated that the patient's regression could not be categorized as benign or malignant in the moment. This was based on a longitudinal view which assumed that regressive phenomena are an expected part of the therapy and that it is in the therapeutic work that the regression becomes therapeutic or remains pathological. Thus, this therapist considered all regressions as a general phenomenon until there was some subsequent outcome to determine its status. This is conveyed in the following quote:

> I don't think you can tell in the instant whether the outcome is going to be therapeutic, whether you're going in a bad direction or a good direction from that point. Its more a function of the accessibility of the patient to an analytic exploration of the event, which may take minutes, hours, many sessions to tell.... I have some history with the patient so I may be relatively optimistic or pessimistic but, other than that, I don't have any idea.

This therapist's position on regression was the basis for the researcher dropping the terms therapeutic and pathological regression and substituting benign and malignant respectively. It appears that all regressions have the potential to be therapeutic given enough time and the right circumstances in the patient and the therapy. Hence, the

term "therapeutic regression" was not useful and precise in identifying the phenomenon. In this research the terms benign and malignant describe the nature of the regression as it is manifested in the moment in relation to the therapist and the therapy. Thus, not all regressions are benign in the moment.

The determinants reported for regression in general are consistent with the data for benign and malignant regression. In general, the patient's characterological structure and level of development are seen as important determinants for the nature and disruptive potential of the regression.

One therapist added that structural factors alone should not be equated with the potential for a benign regression. With more structurally defective patients there is a greater potential for malignant regression. However, because of the nature of their ego and self structures, and their more intimate contact with primary process experiences, these patients were also able to enter into a benign regression under the right circumstances. In contrast, some patients with fewer structural deficits are less prone to a benign regression due to the rigidity of their personality structure, and general avoidance of any primary process experiences. This is illustrated in the following quote:

> ... with the higher order [structurally more intact] characters ... you probably have less opportunity for pathological regression in the sense that their characters are typically more unidimensional, more stable, and more solid. So, they often times don't dip into certain aspects of consciousness that one might have to dip into in order to see regressive kinds of problems. In that sense they may be less prone to pathological regression. They would also be less prone to healthy regression too. These are the same people that can't

> play, that have trouble being creative, that can't loosen up and ... have a novel thought ... its not linear. ... those people who have greater impairments or constitutional deficits, while ... they are in one sense more vulnerable and at risk for certain emotional upsets. Its also true that they have more possibilities for ... constructive regression, just because of the availability of things there is to learn. ... One is not necessarily better than the other, and that either side has got its problems.

Thus, the relationship between character structure and the potential for a benign regression is not linear. This point also serves to indicate that the therapist cannot immediately determine from the patient's structure alone what direction the regressive possibilities will take.

As stated earlier, all regressions are potentially therapeutic based on the patient's subsequent capacity to analyze it and integrate it into the therapy process. One therapist indicated that whether or not it is ultimately analyzable is a function of the patient's level of self and interpersonal development.

In order for any patient to eventually reintegrate a malignant regression as a therapeutic experience, the therapist indicates that the patient must have achieved a triadic level of development. This reflects a shift away from an egocentric and self-centered orientation towards an empathic orientation towards others. It allows for the experience of others as real and separate.

Within the therapy process this capacity allows the patient to step outside of the malignant regression at some point and enter into a collaborative venture with the therapist. When the patient is unable to do this, because of a failure to have achieved the necessary level of development, then the distortions of the therapist remain fixed. In

this case, the patient has no capacity to get any distance and enter into a joint exploration of the event with the therapist. This is when a patient is unanalyzable and intractably regressed.

The determinant for this is again to be found in the patient's character structure based on past events and experiences. In the following quote the therapist states that the patient's capacity to take a malignant regression and make it a therapeutic experience is determined within the first five years of life:

> The triadic configuration of the oedipal period means the end of a self centered world. As long as relationships are dyadic, even though there's an other, the other is always centered around oneself. And realizing that the interpersonal world is not organized that way is the foundation for empathy. In it's absence, analytic work becomes very difficult. ... and that is not a preoral development but an oedipal development, because the other is real and not ... centered on oneself ... a lot of people get some of it so there's some capacity to work with them. But a flat out failure ... would mean an unanalyzable patient. Even if their self structure seems relatively intact ... There are people with relatively solid self-esteem who are nevertheless unanalyzable.

In general, regression is seen as a universal phenomenon which can be experienced as either benign or malignant in the therapy based on several factors. There are also other regressive phenomena which are more subtle but also universal. One therapist described a general form of regression which emerges within any context, both inside and outside of therapy. Thus, it appears to be a regressive experience of everyday life. It involves the recovery of memories, affects, and experiences which had previously been unavailable or inaccessible to the person.

In therapy, the transference neurosis can precipitate this type of regressive experience. Outside of therapy, it can be evoked by any one of a number of experiences including talking with someone or watching a

movie. This regressive phenomenon appears to occur when some situation or event in the present parallels an event in the past. Within the therapeutic process, this is welcomed and serves to make the past available for exploration in the present. This example reflects the ubiquitous though often subtle nature of regression and regressive phenomena.

Regressive phenomena were seen by all the therapists as generally difficult to describe and explain. Regression, as a natural, dynamic, and pervasive phenomenon was difficult to capture within a static and concrete representation. Due to the various manifestations of regression, several therapists indicated the need for more conceptual and metapsychological constructs to provide a structured and integrated understanding of the phenomenon.

In attempting to explain and conceptualize regression, the therapists indicated that it involves various dimensions linked by the presence of earlier or past levels of functioning and experience in the present. Within the therapy, the process of uncovering or reactivating earlier levels of functioning makes overt what was always present and active in a person's functioning, but often outside of their awareness. Thus, the therapists indicated that the process reveals a regressed state or level of functioning which is constantly there and exerting an influence on the patient's current functioning. This is an important concept since it conveys that regression is a process which brings into focus a level of functioning which has always been present in some form. This process is presented in the following excerpt:

> ... I think regression, and the experience of regressive forces are an aspect of daily life. It can be a process of uncovering developmentally less mature levels of functioning and experience. That can occur as a result of the content and the process emerging in psychotherapy. It can also be a reactivation of earlier experiences, trauma, or conflict about which the patient has been unaware. And, to the extent that the patient has been unaware of these forces within himself or herself, those factors have very likely been present and active as primitive processes in their functioning. I think that regression is a unitary phenomenon which occurs in essentially the same form in all people.

The implications of this conceptualization of regression lead to the position that the patient's functioning cannot be separated into higher and lower levels or secondary and primary process. This type of discontinuity is not an appropriate way to conceptualize a patient's psychic functioning. These elements coexist and constantly interact, but the process of the interaction is not always evident.

Through the process of regression, the unconscious and earlier elements become figural and manifest. These are elements which were always actively present, and not dormant and waiting to be awakened. This view is evident in the following quote where the therapist indicates that regression is not a "going back" to the past, as a time travel sort of metaphor, but an emergence of what has always been carried by the patient in the present:

> I don't feel like I'm going back to something way back then. I think it's something that's being carried by the person right now.

Consistent with this conceptualization, two of the therapists indicated that primary and secondary process phenomena should not be categorized in terms of one being a higher function than the other. They are both seen as developing and interacting together in the

patient's functioning. When either form dominates, then there are problems. The primary process experiences become frightening and lead to a malignant regression when the controls are lost.

All the therapists indicated that the potential for regression, either benign or malignant, is always present. One therapist stated that there is a universal attraction to regression as a means of exploring, understanding, and presumably reworking previous experiences in terms of early primary attachments. This is consistent with other data from other sections which identify a natural process and tendency to rework past events.

Conceptually, the issue arose regarding what a patient regresses from and where they regress to. There has to be a level of progression which has already been achieved from which a patient regresses and to which they can potentially return. Thus regression and progression are linked.

Where the patient is when they regress was a difficult issue with some divergent views between the therapists. In general, the therapists indicated that the patient does not regress to a particular level or state so much as to a particular issue or area of conflict which needs to be reworked. However, four of the therapists added that a patient could also regress to a pretraumatic state.

One therapist conceptualized that regressed patients present a self and object fluidity which is characteristic of the developmental stage prior to individuation and separation, where the boundaries are not clearly delineated. Therefore, the presence of a sense of merger with a good object is gratifying, while merger with a bad object is

terrifying, reflecting the patient's potential experiences in a benign versus malignant regression, respectively.

An important conceptual issue addressed by all the therapists involves whether or not the two forms of regression represent discretely different phenomena, or the same phenomenon. The general view was that the two forms of regression represent different points along a single continuum for a unitary phenomenon.

The Therapist's Self-Experiences: Benign Regression

This category deals with the therapists' descriptions of their own experiences. This includes their personal experiences as well as what they perceive to be the experiences of other therapists.

With a patient entering or already in a benign regression, the therapists generally reported that their self-experiences were positive. Their affect tended to be positive and brighter, with a more optimistic view of the course of the patient's treatment. This was usually contrasted with the more negative affective experiences which many of them had with patients in a malignant regression. There was comparatively less affective intensity, and a general absence of intense fear or terror in the therapists' experiences.

Even when a patient in a benign regression presented some negative transference, the therapists' experiences tended to remain positive since the therapeutic process and relationship remained intact. One therapist indicated that the general lack of affective intensity for the therapist, with a patient in a benign regression, contributes to these experiences having less definition and prominence compared to

experiences with patients in a malignant regression. These qualities of the therapist's experience are illustrated in the following quote:

> It is a process that rarely stirs up disruptive induced feelings in the therapist. There is another barometer. One [the therapist] is not as likely to feel on the edge of a cliff. One is not as likely to be as enduringly terror struck .... It doesn't stand out as much. It's not as affectively charged. So the memories are not as likely to be cathected.

With a patient in a benign regression, one therapist indicated that the therapist's countertransferences were more variable and indicative of the their own dynamics within the interaction with the patient. This was contrasted with the patient in a malignant regression where the therapist's experiences reflect a more direct response to the patient's affects and behaviors.

The therapist's affective and cognitive experiences can parallel the patient's experiences during a benign regression. Therapists can experience a quality of playfulness with a letting down of their defenses. Thus, they can more easily access their own primary process experiences, and share these experiences more directly with the patient. The interaction with the patient can reflect a genuine sense of intimacy during these times, as illustrated in the following text:

> With the benign regression, the main thing that happens is a general feeling of letting down of defenses, and even a letting down of secondary thought processes. There's a more relaxed atmosphere, and a capacity to play with associations in my mind. To feel more positive, more relaxed about the person. And probably, a greater willingness to share some of my thoughts with the patient. ... I feel much more comfortably together with the person, and much more relaxed about the relationship. And probably, I'm functioning much more at a primitive level in the relationship back and forth with the patient. Much more playing around with primary process ideas.

An important determinant for a patient entering a benign regression involves the parallel process of the therapist's willingness to accept the regression. The therapist must accept it for themselves and allow it for the patient. This can involve either a conscious or unconscious acceptance which is essential and necessary for the process. The therapist's need to accept and allow the regression is conveyed in the following passage:

> I think there's a mutual regression in the course of a treatment. We use words like the therapist is more controlled. The jury is still out on that for me. There are times in treatment where one's critical judgment has to get suspended. You have to go with the flow, with what's occurring. ... if you're always processing it as its occurring then, by definition, you're not allowing it to happen. I tend to believe that there needs to be enough letting down of the guard on both sides for ... regression to occur in the patient ... it takes longer for the therapist to be willing to permit the regression. If the therapist is too reality bound, too many facts ... it takes longer for that to develop, if it develops at all. ... we need to get out of the way to let it happen.

Therapists' who interfere with the patient's regression, by remaining concrete and reality oriented, are seen as having a countertransference problem, usually around letting go of controls. In the other direction, therapists' can also have countertransference problems around trying to force or engineer a regression when the patient is not ready. This reflects a lack of attunement to the patient's needs and the therapist's preoccupation with their own needs. The latter problem is illustrated in the next quote:

> I do alter how active or how not active I am in sessions, depending on where the patient is at. ... it would be the thing to do therapeutically, not because I am going to be quiet in order to engineer a regression. If that happens, if I do engineer it then its pathological. That's not responding to where the patient's coming from. I'm impatient with the flow of it, or its taking too long, or something else, that's a

> countertransference problem that I'm acting out with my patient. That would not be good.

In order to allow the patient to enter a benign regression, the therapist must have a tolerance for ambiguity, and the capacity to function and maintain control with little external structure. The therapist must also be responsive to the patient's process and allow the regression to unfold at its own pace. They must be aware of when to be silent and not introduce interpretations or secondary process into the interaction since this can derail the regression. On the other hand, therapists must also know when to step in with information or controls to facilitate and manage the regression when needed.

The Therapist's Self-Experiences: Malignant Regression

The therapists' descriptions of their experiences with a patient in a malignant regression also tended to parallel the patient's experiences. Therapists reported often feeling anxious, startled, fearful, and overwhelmed with a patient in a malignant regression. Their affective responses tended to be negative, and the opposite of what was generally experienced with a patient in a benign regression. This is illustrated in the following quote:

> ... in the malignant regression it makes me feel wary, somewhat suspicious. Sometimes, what I refer to as clinically paranoid about the situation.

The therapists reported often being surprised and startled when a patient entered a malignant regression due to its intensity and often rapid onset. They also reported feeling under siege and having to work very hard to reestablish a sense of distance and boundaries with the patient. These experiences are illustrated in the following quotes:

> Pathological regression tends to be surprising ... It has a force and intensity that, at the very least, provokes some anxiety in the therapist, if not becomes frightening. And that's probably tied to the fact that it wasn't expected and you didn't see quite what it was coming from.
>
> So much of what happens is based on very broad, compelling affects that one feels pretty much powerless to do much about.
>
> It just sweeps you away and you can't get back. You lose your perspective. You are the bad mother during that time, there's no way to get out of it.

In the process it appears that therapists tend to lose their empathic attunement with a patient in a malignant regression. Even after the patient is out of a malignant regression, there appears to be some difficulty in reestablishing an empathic response to the patient at times. Speculatively, this may reflect the therapist's attempts at distancing in order to avoid precipitating the patient's malignant regression and reexperiencing the sense of being uncontrollably immersed in primary process themselves. This may parallel a similar distancing process in the patient.

The recurring parallels between the patient's and the therapist's experiences in a malignant regression may reflect the operation of projective identification. Several therapists indicated that their experiences were direct responses to the patient, and one called them "induced feelings" and not countertransference experiences. Another therapist directly identified that their feelings were the result of the patient's projective identifications. In general, the therapist's intense experiences, which parallel the patient's in a malignant regression, appear to reflect the patient's projective identifications rather than the therapist's own countertransference issues. From a

therapeutic perspective, these projections can be used to intimately understand the patient's experiences in a malignant regression.

In going through a malignant regression with a patient the therapist can often feel overwhelmed, with the belief that the treatment is out of control and an increasing uncertainty about their capacity to reinstate control. This can lead to serious difficulties in the management of the patient's regression if the therapist is unable to maintain their own sense of control.

Once the therapist has gone through the malignant regression with the patient, several factors become important as determinants for what effects it will have on the therapeutic process and relationship. One of the therapists indicated that there is often a tendency to blame the patient for the regression. However, the regression was most likely precipitated by the therapist through some technical error or failure to understand what the patient needed. This is conveyed in the following passage:

> I think that most of the time, the malignant regressions occur because of therapeutic error than they do because of patient resistance. I think we often times dump it on the patient, when really the therapist doesn't exactly understand what's going on in the situation.

The therapists indicated the need to accept responsibility for the patient's malignant regression and to directly acknowledge this to them as an error and explain why it occurred. If the therapist does not acknowledge their role in the patient's regression this may serve to dismantle the treatment process. In general, the therapist has to understand the patient and avoid those situations which might precipitate a malignant regression. This reflects the therapist's

attunement and capacity to maintain the controls for the patient. This is illustrated in the next quote:

> I assume responsibility for it in the sense that, I should have sufficient understanding to either have anticipated it, or have warned the patient. Or, between the two of us, figured out what we were getting into and decided not to get into it.

One therapist indicated that how one conceptualizes and treats a patient in a malignant regression is often determined by the therapist's own dynamics. Several therapists indicated that malignant regression was an extreme case of a normal human experience. They also indicated that some therapists attempt to distance themselves from this possibility by treating malignant regression as something totally removed from everyday human experience. The therapeutic implications of this attempt at distancing are illustrated in the following quote:

> If you think of pathological regression as something separate and apart, you obviously want to look at it differently treatment wise than if you looked upon it as perhaps nothing more than some extreme of normal human experience. It also addresses a lot of issues, if you see it on a continuum the way I do, as to why so many therapists don't want to fool around with it. Why many therapists do not want to deal with acute regressed states, having to do with what this must mean to them as a human experience. They just keep away from it. And to be very concrete, why is it that so many people are afraid of madness? But madness in the sense of uncontained pathological regression is something that all of us are vulnerable to.

One therapist also presented some personal experiences with their children which, interestingly, reflected how they developed a better understanding of malignant regression in the process of caring for them. This provides a concrete example of how therapists draw on a variety of clinical and everyday experiences, as well as abstract theoretical constructs, to understand and explain human functioning, and malignant regression in particular in this case.

The Therapist's Self-Experiences: Regression in General

The therapists' descriptions of their own experiences with general regressive phenomena are also consistent with the previous data. Thus, there tends to be a parallel process between the patient's experiences and feelings and those of the therapist's. In the following quote, the therapist indicates the need to maintain a therapeutic barrier in order to maintain some distance from the patient's affects and experiences:

> I think more primitive regressions tend to evoke a more primitive response. And I think the therapist does need to maintain what some people call the therapeutic barrier.

In the next quote, the same therapist also indicates that in an attempt to survive the patient's regression the therapist's response to the patient sometimes reflects a self protective maneuver. This is often directed at mitigating the patient's distortions of the therapist with an attempt to reinstate the positive transference:

> It gets particularly difficult because very often, particularly if you're dealing with patients who have some relatively primitive deficits, the therapist's so called therapeutic intervention, is a self protective effort. With the unconscious, preconscious intention of reasserting some kind of formality in the situation. Saying, "don't forget, you're a patient I'm the doctor, this is not out of control. You're not supposed to really be mad at me, those aren't really real feelings, what you really mean is," that kind of stuff.

Generally, therapists can have a number of difficulties in response to a patient's regression. One therapist indicated that many therapists had difficulties in dealing with issues of dependency, and feeling helpless, and the potential to be out of control. This was seen as resulting in their resisting regressions in their patients. Consequently, it was suggested that therapists undergo intensive therapy themselves in order to resolve any possible problems in

accepting and dealing with the patient's regression. One therapist presented their personal experiences with a rather primitive regression within their own therapy. This illustrates how a therapist's personal experiences with regression can help them to understand and deal with their patient's experiences.

In terms of the explanations for regression in general, therapists were asked to present their theoretical and conceptual sources for understanding the phenomenon. They were also asked if the current theory and understanding of the phenomenon sufficiently met their clinical needs.

There was some variability in the therapist's theoretical and conceptual sources for understanding regressive phenomena. However, there was a basic psychodynamic orientation professed by all the therapists. As conveyed in the next two quotes, some of the therapists indicated that the existing theory was inadequate, and often did not provide answers or direction in dealing with regressed patients:

> ... often times I would have this experience with patients and then I would go back and read what other people had to say about it. The thing that always bothered me is that they didn't have much to say about it.

> ... I don't think they cover all bases where I can just look it up in a cookbook and say "OK, this happened, now what do I do here." No, for the most part they're not sufficient.

Based on the data, what the therapists presented in their interviews with the researcher generally involved some mix of clinical experience and theoretical background. In the sections on descriptions and determinants it appeared that the clinical experiences were the

main source of what therapists presented. Thus, theory did not appear to dominate their experience of the phenomenon.

The Therapist's Experiences of the Relationship with the Patient: Benign Regression

The nature and quality of the patient's regression and their relationship with the therapist can both vary significantly in a benign regression. For some patients, the regression and the relationship can be very positive. For other patients more conflict is evident in either the regression or the relationship, though both tend to covary. In all cases, however, the relationship remains fundamentally intact and available to the patient through the course of the benign regression. This can include temporary fractures in the relationship which are subsequently mended.

Where both the regression and the relationship are very positive, there is a positive ambiance between the patient and the therapist. The patient's affects are generally positive and there is a predominantly tranquil and serene quality to the regression.

Prior to entering this kind of benign regression, the patient's transference phenomena and distortions tend to be less prominent, conveying that the patient is responding primarily to the real aspects of the relationship with the therapist. The relationship has the quality of a joint endeavor where the patient accepts the role and function of the therapist in the regression. This reflects the patient's belief that the therapist knows what they're doing and will use this knowledge to help them.

The relationship described here is characterized by the patient's trust in the therapist. This is illustrated in cases where patients fell asleep in the session. Upon awakening, the patients invariably felt refreshed, and sometimes euphoric. This reflected the degree of security in the relationship, where the patient was not fearful that the therapist would be gone when they woke up. The following quote reflects a number of the points which have been cited about the quality of the relationship in a positive benign regression:

> ... the patient is, after a long period of time, starting to regress. And it has to do with a solidification of the relationship and a trust in the relationship, to the extent very concretely, he can fall asleep here with me and know that I will be here when he wakes up. ... it will not interfere with the stability of the relationship, and he's ready to be taken care of. And I think that this is the sine qua non of benign regression. It has to be in a safe interpersonal context, in which the therapist is willing to take responsibility for whatever it is that comes up. In that sense, it is a recreation of a parenting kind of ambiance in which one person takes responsibility for someone else. With that kind of ambiance people regress while they're wide awake and it is controlled. Now with this particular man, it not only is benign, it is very pleasant. He has a sense of well being. When he left he felt good. And often times, patients will tell you when they fall asleep during a session, when they wake up they feel almost euphoric. They feel really good.

Therapists used various terms to indicate that patients had to develop a solid alliance, bond, or attachment to the therapist in order for the degree of security to reach this level. This allows the patient to deal with primary process experiences and affects with a sense of control. The relationship establishes a feeling of security that these experiences can be contained, and will not be overwhelming for the patient, since they are not alone in dealing with them.

The therapists presented several metaphors for the relationship which generally described a "holding environment" where the patient felt held and protected. The recurring metaphor, implicit in the sense of a "holding environment," is the parent-child relationship. This was explicit in the previous quotation. Other therapists, either directly or indirectly, conveyed how their role was much like a parent, tending to the patient who was usually in a child-like role. The patient's sense of being securely held, in a parental type relationship with the therapist, is illustrated in the following excerpts:

> ... [while in a benign regression] the person would take off in fantasies about me and about the world. But the fantasies about me were in terms of a very powerful paternal figure, like a father who was very kind and holding the person. ... And, either the person would be held like an infant, or an older child sitting on my lap and telling stories about what was going on. ... It was like that was really happening. The person was actually like a little kid sitting on my lap talking about events or things that happened or just resting. And that's often a quality that would happen in this case, where the person would peacefully be quiet, not in an agitated resistant silence, but be quiet and feel very supported during the quiet period.

> The patient would come in very tired, and have this overwhelming urge to lie down on the couch. ... And she would literally assume a fetal position. ... When she would awaken it was apparently a very positive experience for her. She was excessively grateful to me for allowing her to do that. ... What we reconstructed was that it had to do with the concrete creation, for her, of the holding environment. ... she was able to feel held and protected in the presence of a parental figure. Once she had been doing that, she began to have access to a great deal of material about being an infant.

Therapists reported that patients often sought, consciously or unconsciously, to create this type of relationship and environment within the therapy. It appeared to be something the patient needed to do in many cases. In some cases it was the process of creating and

maintaining this relationship and environment which was more important to the patient than dealing with whatever content emerged.

Interestingly, with this type of relationship in place, therapists would often describe themselves as becoming non-figural for the patient. The patient knows the therapist is there, but is not directly interactive with them. When this occurs, it appears that the strength of the relationship allows it to be taken for granted as a constant given by the patient. This is conveyed in the following quote:

> Its like you move to become a part of the environment. ... the person begins to talk and explore things in a way as if you're not there. Its ... assumed you're there. ... you become ... a comfortable part of their environment. And ... they're thinking about something internally.

From the other side of the relationship, therapists indicated that they needed to willingly accept the responsibility of tending to and caring for the patient. This involves assuming the responsibility for maintaining the security of the environment and the controls for the patient when necessary. Thus, the therapist must maintain a measured and sometimes subtle but active role in the patient's regression. This requires that they remain attuned to what the patient needs at any point in the therapy.

These aspects of the relationship between the patient and therapist are present to varying degrees in all benign regressions. Some differences are evident, however, when the regression is more turbulent and the relationship reflects some degree of conflict. For some patient's the relationship is more openly conflicted at times, with negative transferential elements being more prominent.

One therapist presented an example of a regression where the patient's transference resulted in the relationship assuming an adversarial quality for awhile. Here the patient experienced the therapist as a paternal figure from their adolescence. The reliving of this earlier relationship through the transference was seen as an indicator of the patient's entrance into a benign regression. The regression remained benign because the therapeutic process and relationship remained intact.

This conveys the dichotomy or split which can exist in the patient's experience of the therapist. Negative transferential elements can co-exist with more positive real elements. The regression remains benign as long as the potential distortions are contained and do not lead to the patient completely losing the real aspects of the relationship with the therapist.

Another therapist presented a case where the patient moved from a malignant regression into a benign regression. However, due to the remaining negative transferential elements, the patient was still somewhat conflicted about the relationship with the therapist. The patient's benign regression was somewhat turbulent and the relationship reflected some distancing and fear. The therapist indicated that the shift from a malignant to benign regression was signaled by the patient becoming more real, as well as child-like, in her interactions with the therapist and family members. The regression was again benign because the therapeutic relationship and alliance was maintained.

The strength of the relationship becomes a critical factor in cases where the benign regression is intensely turbulent and

distressing for the patient. Some of the therapists indicated that this is a typical course for a benign regression. Here the patient's experiences in the regression are potentially overwhelming, but still contained and controlled as a result of the relationship with the therapist. The relationship serves to maintain the control necessary for the regression to remain benign. The metaphor of the parent-child relationship is again quite evident in the therapist's role of assuming control for the patient when this is needed. An example of this type of benign regression is presented in the following passage:

> Had another patient whose in a benign regression which is much more typical. ... An enormous amount of anxiety, fear, sense of dread, a fear that she's falling apart, a fear she's crazy, a fear that she'll never get well again. All the things that I associate with pathological regression, except its in the context of a relationship. The only difference between a pathological experience and a benign regression that she's experiencing is, the relationship is the only stabilizing force to help her contain her panic. And occasionally her panic anyway erupts, and she'll call me. Last week I had to come in on Sunday to see her, because she was having a terrible time. And so, we spent some time talking. ... because no one has ever sat with this woman when she was in distress. And its part of what's the matter with her, she's never had that experience.

The therapist's role with a patient in a turbulent regression is generally described as more active relative to their role with patients in a tranquil benign regression. This can involve more direct management and intervention in order to quell the patient's distress and keep the relationship and controls intact. This can include helping to organize the patient and pace them through both the sessions and their everyday functioning between sessions.

The therapists emphasized the need to generally avoid evoking any additional negative transference with patients in a benign regression,

and especially with patients in a turbulent benign regression. In one case example the patient presented fears that the therapist might recapitulate a past negative relationship. This would have potentially diminished the capacity of the relationship to contain the regression. Thus, the patient was aware, on some level, of the therapist's role in keeping the relationship and controls intact for them.

In general, the benign regression is not characterized by one state or level which the patient must attain. It is an individualized phenomenon which varies in relation to factors within the patient, the therapist, and the relationship. However, the maintenance of the therapeutic relationship is the one essential factor which remains constant across all levels and types of benign regression.

The potential for a benign regression appears to be determined by the interaction between the patient's past history, including their object relations history, the resulting ego and character structure, and the relationship with the therapist. The structural factors have been addressed in other sections. The central role of the relationship is conveyed in the following quotes:

> Therapeutic regression is a process that can only occur within the context of a sound therapeutic relationship. ... when the patient and the therapist have been able to establish a real therapeutic alliance.

> First of all, you have to have a stable attachment. ... a working alliance between you and the patient.

There are very specific qualities to the relationship which determine whether or not a benign regression will unfold. There must be a level of trust attained where the patient willingly lets the therapist in behind their defenses. A general working alliance is not

sufficient. In order for this to occur the patient must believe that the therapist is emotionally invested in the process and the relationship. The patient also needs to experience the therapist as constant and dependable so that they always knows what to expect from the therapist and can count on them when necessary.

One therapist added that the patient must also have trust in themselves. The patient's trust in the therapist, and in themselves, seems to center around the capacity to maintain the controls and containment needed to keep the regression benign. Here, the patient must trust the therapist to understand what is happening in the regression and to do whatever is necessary to facilitate and maintain the process. As this trust develops the patient defers more control to the therapist. This degree of trust and security requires a good deal of time to develop. This is illustrated in the following excerpt:

> At some point you got to believe this guy knows what he's doing. And you may as well get out of his way and let him do his thing. The patient needs to do something like that ... has to believe that you know what you're doing. That's what takes time. To develop that sense of rapport, where the patient can say "well, I guess he probably does know what he's doing, lets see."

The therapist in the quote below indicates that this does not mean that the patient views the therapist simply as a benign figure. The patient's continued sense of security and safety hinges on their trust that the therapist will do what is necessary to help them rather then what best suits their own narcissistic needs. Thus, the patient can rely on the therapist to do what is right, even if this initially offends the patient. Implicit in this is that the patient knows, at some level, what they need and whether or not the therapist is

responding to this need appropriately. These points are illustrated in the following quote:

> ... the sense of security that the patient feels. ... does not necessarily imply that the patient sees you as a benign character. ... for treatment to be successful, the patient also needs to experience the therapist as having a certain commitment to understanding, no matter what, no matter who gets offended. ... that's the kind of security that I'm talking about. That's not the same as saying ... you're going to like me, or ... you're not going to do anything that I don't like. ... the therapist is going to be experienced as someone who isn't exclusively committed to the maintenance of his own self-esteem. ... [but is committed] to some understanding that he is not threatened by.

Within the relationship, the therapist cannot be fearful of what emerges in the treatment process. They also cannot be fearful that their actions will jeopardize the relationship. Thus, they also have to have trust in the relationship.

Where the patient has lingering doubts and anxieties about the regression, this generally conveys their concerns over the therapist's capacity to maintain the safety and security of the relationship and the necessary controls. This is often evident at the beginning of the regression, but can continue throughout the regression. However, even with patients in a turbulent regression, a sufficient degree of safety, security, and trust has been established in the relationship to allow the benign regression to proceed.

When the trust is well established patients are basically less fearful of being abandoned or betrayed by the therapist. The therapists indicated that they often did not know how much trust had been established within the relationship until some specific event or demand arose which tested it. In some cases, patients who appeared

well integrated and trusting were unable to enter into a benign regression because of a basic underlying distrust which could not be overcome. This is illustrated in the following passage:

> I'm working with a man right now, and we have come up against this invisible wall, which I had not anticipated, I was really surprised. ... The guy is very integrated, high level functioning person. ... My consultant ... said, "... this man has a thought disorder." ... I thought about it, and then everything started to make sense. And in that thought disorder lies an absolute distrust of everybody. So you're dealing with a person who, at the core, trusts no one. Outside this inner keep, if you will, he can carry on like ... [he] is at home with everyone and everything. And he does it beautifully.

The issue of a basic capacity for trust was addressed by several therapists in terms of the patient's early object relations history. They indicated that there have to be specific precursors in that history which will allow for the necessary degree of trust required for a benign regression to proceed.

In the following passage, the therapist indicates that the patient must have experienced at least one significant past relationship which was positive, and established that something good and constructive could occur between people. This establishes hope for achieving and maintaining a secure and constant relationship in which ego development can proceed. The positive past relationship becomes an anchor for the subsequent trust which is necessary in the therapeutic relationship. This conveys the constant interaction between past and present relationships in a benign regression. The therapist states:

> The biggest factor for a benign regression ... is that in someone's developmental history ... they had some significant experience with a positive object relationship. ... It's a relationship that might have been forgotten about by the patient. But generally ... if something did in fact happen that was positive, they can have an anchor point or a memory

> that something good can take place between people. If its in there somewhere, and often there can be very negative relationships all around it [a benign regression can occur]. But, if it never happened to a significant degree ... then to have a benign regression take place is almost impossible.

Aspects of the past positive relationship generally become integrated into the relationship with the therapist. Some therapists identified this as the positive transferential aspects of the alliance. The patient may have also had a number of negative past relationships, which can find their way into the relationship with the therapist as negative transference. However, as long as a substantial positive relationship occurred in the past, the patient still has the capacity to develop a trusting relationship with the therapist. Without a positive past relationship, and without a capacity for trust, the benign regression is not possible.

Another critical determinant for a benign regression involves the therapist's capacity to maintain an empathic attunement to the patient. This allows for a close monitoring and sensitive awareness of the patient's experience in terms of what they need from moment to moment. The following passage illustrates the importance of the therapist's attunement:

> ... it's the attunement the therapist has with the patient that assists in creating the possibilities for the regression to be positive or negative. You either have affective attunement that's on the money, that promotes new possibilities ... or you have little misses that will occur, empathic failures ... that are inevitable. And even those ... still create possibilities for working though. ... If the patient feels the therapist is attuning in a constructive, positive fashion, then the patient will show more and more, and will go ahead and move into these territories.

As part of the therapist's attunement, they must be willing to accompany the patient into the regression. Thus, it is a two person event throughout the process. Difficulties in following the patient into the regression can lead to a termination of the benign regression. In this process, the therapist must also maintain enough distance so that they can still have a cognitive understanding of what is going on. This allows the therapist to maintain an overview of the process and the context while in the regression with the patient.

Besides the specific relational factors already identified, all of the therapists indicated that there were general environmental manipulations which they used, in some cases with specific patients, to facilitate a benign regression. These included the use of a couch, not facing the patient, talking less, and reducing other forms of external stimulation in the patient's environment. In general, these concrete steps were intended to introduce less structure into the situation. While these general maneuvers do not produce a regression, they are seen as helpful with some patients in facilitating an inward focus and internal preoccupation which allows the regression to emerge.

When the necessary factors are present and in place, the stage is set for the patient to enter a benign regression. At this point there appears to be a critical juncture in the process where the patient's emerging regression requires a specific response from the therapist. This involves the therapist's recognition of the patient's regression, and then their acceptance of the regression which is concretely and nonverbally communicated by doing whatever is necessary to allow it to unfold and deepen. This is illustrated in the following quote:

> The benign regression, when it starts to happen, it seems very important at that point to recognize it and then, in a positive way, to keep myself out of the way. In other words, not to get into any pseudoactivity to try to prevent it or not to introduce my ideas about it, but just to allow it to emerge. And, if I check the situation and see that the usual things I look for in a negative regression aren't there, then what I generally do is pull myself back, pay attention, but stay out of the way. It's like I become the guardian of the event, but I'm not actively trying to do something to the event. So, when I can do that, it seems like that's the most important thing within the therapy that allows it to happen.

Once the regression emerges, the relationship with the therapist can become nonfigural for some patients. The therapist's role as a "guardian" conveys the sense of being with the patient, to insure that the regression is maintained, but sufficiently on the periphery to avoid intrusion or interference with the process. This is a delicate and difficult balance to achieve in many cases. Clearly, the relationship remains the anchor for the patient's benign regression to continue on course.

During the course of the regression, patients were seen as needing different degrees of support and management in order for the process to proceed. In some cases this only involved giving the patient information about what was happening. Other patients required more direct or active support by the therapist. In the following passage, the therapist indicates the need to act as a guide, who tends to the patient's fears and anxieties, while helping to maintain control:

> To make [the regression] ... as smooth as possible I'm the tour guide. I describe what we're seeing as we pass it. It tends to contain the level of fear and anxiety. If these things are some kind of peculiar experience to the patient, completely devoid of something shared by other human beings, then they really are frightened. But, if it turns out I can honestly say "oh, I've been here with other people and I know what happens, and you don't die .. and you don't atomize." If there's a

strong relationship you can see how then it will work. It will help moderate their fear.

In this process, both the timing and the specific activity of the therapist are critical to the maintenance of the patient's regression. For example, one therapist indicated that the introduction of secondary process activities, such as interpretations, can lead to different results at different times. It can serve to bring a patient out of a regression prematurely when employed inappropriately, or it can serve to keep the process under control at another time.

In managing the regression it is essential that the therapist maintain the regression within the controls and containment provided through the relationship. This requires an ongoing attunement to the patient in order to assess what is going on, and a full understanding of the limits or capacity of the relationship to contain the regression. This allows the therapist to know when a benign regression may be moving into a malignant regression.

All the therapists indicated that the patient's ego or character structure must be taken into consideration in the management of the regression. Patients with more pronounced structural deficits require more activity and direct management in order to contain and control the regression. With these patients there is a fine line between the benign and malignant regression, with the differentiation generally determined by the capacity of the relationship to maintain the controls and avoid decompensation and disintegration. This is conveyed in the following excerpt:

> For some patients who are emotionally vulnerable or have a variety of ego vulnerabilities... regression can often times be

> disruptive, disorganizing. It can result in the issues getting ahead of the object relationship. ... those are typically the patients with the preoedipal structural problems ... for those patients the regression ... will demand considerably more coverage from the therapist, a lot more managing of the affective states, and the pacing and timing. Because, they can get increasingly more disorganized or out of control, where you step into a black hole with them real quickly, and you don't realize exactly what's happening. Before you know it, they're really agitated and flooded. You just know that they're moving towards decompensating, moving towards some sort of psychotic process. That's why everybody [therapists] pulls back real quickly, and they stop doing the uncovering, because it gets so quickly out of control with those people.

Conceptually, one therapist differentiated between benign and malignant regression in terms of the degree of threat which the patient experienced. When the therapist is able to mitigate any threat and maintain the patient's sense of security in the relationship, then the regression can be benign. Again, benign regression was generally placed on a continuum of regressive phenomena.

It is interesting to note that despite the direct and indirect references made to the parent and child nature of the relationship, the term dependency was seldom used by the therapists. There appeared to be a general reluctance to define the relationship in this manner. For example, one therapist chose to focus on the patient's vulnerability in a benign regression rather than the patient possibly being dependent upon the therapist.

The Therapist's Experiences of the Relationship with the Patient: Malignant Regression

When a patient enters the standard type of malignant regression, identified previously, there is usually some degree of overt conflict manifested in their relationship with the therapist. While regressed,

the patient is typically emotionally flooded and experiencing intense distress. This can reach panic proportions. The relationship generally becomes conflicted as a result of the patient's conviction that the therapist is the cause or source of their distress. Thus, the patient feels justified in directing their rage and accusations at the therapist. These accusations often contain a paranoid quality. In the extreme, the patient can become psychotic with paranoid delusions centering around the therapist. The following passage illustrates some of the complaints which patients direct at the therapist:

> In a malignant regression often the complaints are very negative, very bitter. In the direction of the therapist, I don't understand, I don't care, sometimes I'm making fun of them, I'm trying to humiliate them.

The patient's convictions that the therapist is the source of their distress generally reflects a severe distortion of the therapist and the nature of the relationship. This type of distortion is a recurring element in the standard type of malignant regression. It usually reflects a misperception of the therapist as threatening, destructive, or malignant in some way. For some patients, the distortions can be extreme and include perceptual shifts where they experience the therapist as physically changing and becoming menacing or dangerous.

All of the therapists described these distortions as a psychotic transference, even when the patient was not manifesting other overt psychotic symptoms. The following quote indicates that, in this process, the patient can experience the therapist as if they were a destructive object from their past:

> The way patient's ... describe me at that time, I think I actually become that [past] object for the person. That I'm evil, and I'm trying to do bad things to them, I'm trying to control them. I describe that as a psychotic transference.

This type of malignant regression often occurs early in the therapy, but can also occur at any other time. When it does occur, it generally happens rapidly, and sometimes before the therapist is fully aware of what is transpiring.

The next quote presents an example of a malignant regression which began in the first session. In this case, the therapist was able to move the patient out of the malignant regression. However, the patient remained angry at the therapist, and continued to hold a grudge for what had transpired in the first few sessions. The therapist states:

> The malignant [regression] took place from session one to session six, and it started with the first session. Where a person came into my office, was very emotional, very tearful, disorganized ... talking about a lot of emotional content at once. And the person would look at me in an accusatory fashion and say "look do you understand, are you listening to what I'm saying" that sort of thing. Around session four, the person became very angry with me and in the midst of this thing felt that I was trying to humiliate him, and upset him. ... I called the person back from the regression over and over again, and we got through that part, but the person was very angry about me calling him back from the regression. After ... being recalled from the regression he continued throughout the therapy to be angry about it. But, from that point on, he started to get organized and started to structure things, but always held a grudge about that.

In this example, the patient was initially relieved that the therapist stopped the malignant regression, but nevertheless continued to harbor a grudge about this. This dichotomy in the patient's experience may reflect the interplay between the real aspects of the therapist and the patient's distortions.

All of the therapists indicated that the malignant regression poses a threat to forming an alliance with the patient when it occurs early in the therapy. It also poses a threat to maintaining the alliance and relationship when it occurs later in therapy. In some cases it can lead to a premature termination. However, when the malignant regression occurs later the relationship is usually strong enough to recover. The potential effects of a malignant regression on the relationship is conveyed in the following quote:

> In terms of the treatment process ... that kind of regression [malignant] seems to pose much more of an obstacle to the developing of, at least the working relationship with the patient. I have to work a lot harder to help the patient contain it. When the regression takes the form of exaggerated suspiciousness, paranoid ideations, its very difficult, and often not possible on an outpatient basis.

After a malignant regression occurs, it can result in both the patient and the therapist becoming wary and tentative about the relationship's capacity to prevent the patient from entering another malignant regression. In the following quote the therapist describes this in a manner which conveys a shared hypervigilance over the potential reemergence of a malignant regression:

> ... it [the patient's malignant regression] frightens the patient, and makes the therapist and the patient very wary about the relationship. It serves notice to me as a therapist this whole thing, no matter how its looking, can blow up in a minute. You can never presume there's a relationship there, and so you're always a little skittish about anything you get into. And when something starts to regress you always worry, are we going in the wrong direction here? It's like something happens and neither party ever forgets it because of the frightening, dangerous quality of it.

The standard type of malignant regression described so far involves rather overt manifestations which are palpable, with clear

effects on the status of the relationship. As indicated in other sections, more subtle and elusive types of malignant regression were also described by the therapists.

The following quote presents an example of an insidious form of malignant regression which operated through the therapist's countertransference and the patient's projective identifications. This resulted in the therapist experiencing the fears and terrors of the patient while the patient remained overtly controlled and contained. The therapist states:

> ... the attachment was always an ambivalent one because of my degree of fear in working with this woman, fear that she would kill herself, kill the kid, hurt me. Although I was unaware of that for quite a while. ... I was always holding back a little bit, emotionally, for fear that she would go ahead and do something destructive and end up clipping me, as well as herself. One session she came in ... I remember her reaching over into her purse or book bag. And I knew that this woman was reaching in and pulling out a gun, and was going to blow me away. And the level of the reaction I had, I was almost out of that chair. I remember being really struck with how scared I was about the whole situation. And some of that was a function of myself and the involvement level, but some of it also was a function of where she was at, and that she could not tolerate, at this point in time, any more closeness that was going on between she and I. And, the fear of shooting me and killing me, I took as a projective identification about the dynamic of distancing and about her own retaliatory rage to too much too fast closeness, if it did get out of hand.

In this case, the arena for the malignant regression was the therapist's internal experiences, rather than the patient's overt functioning. This lead to the therapist becoming clinically paranoid, with fears of annihilation. The therapist subsequently understood what had happened in terms of the projective identification mechanisms of the patient placing her own fears over the loss of boundaries into the therapist.

The effects of this type of malignant regression are insidious because they serve to subtly undermine the therapist's capacity and willingness to enter into an alliance with the patient. Thus, it is a highly destructive form of malignant regression, with the potential to operate outside of the therapist's observing ego, and to ultimately undo the therapeutic relationship if not corrected.

Another subtle form of malignant regression, which can also serve to dismantle the therapeutic relationship, is described in the next passage. This involves the patient entering into an idealized merger and fusion with the therapist. It is equally insidious since the therapist is made to feel a false sense of optimism about the status of the relationship. The relationship is not based on any prior interaction or process, however, and therefore is not real. The therapist states:

> The reason I see that [the patient's idealized merger with the therapist] as pathological, its not therapeutically that problematic ... is because the person is willing to make a very strong connection on the basis of nonreality. ... there's not an object relationship. It's strictly a projection, and they have no reality data yet to begin to fasten that to. ... if it goes on too far, then you're setting up problems later, down the road. If there's anything that deviates from that idealization, it could be very destructive to the therapy. It ... could break up the positive transference.

The therapist indicates that this type of malignant regression poses a threat to developing a solid relationship with the patient. In this case, any ensuing movement by the therapist away from the idealized image, which has been created by the patient, can lead to a devaluing of the therapist and a collapse of the relationship.

In addressing determinants, the therapists acknowledged some degree of responsibility for the patient entering a malignant regression. This usually involved some failure on their part, within the relationship and interaction with the patient. The patient's structural ego defects were acknowledged as necessary, but not sufficient factors for the patient to enter a malignant regression. The therapists indicated that the controls, which were seen as necessary in order to avoid a malignant regression, were usually maintained or lost within the context of the relationship.

In this context, technical errors by the therapist were seen as the major precipitant for a patient's malignant regression. The errors could result from two factors, which are intertwined. The major factor involves a failure in attunement to what the patient needs at a particular point in the therapy. In the following quote, the attunement is described as an empathic responsiveness, in which the therapist is in tune with the patient's internal process. This provides both an affective and cognitive understanding of the patient. It is the kind of attunement which is often seen between a mother and her infant. The therapist states:

> ... the attunement is critical. ... [the therapy] can go off line if the therapist is not emotionally attuned and sensitive, not emotionally involved in the process ... there will be no attunement under that arrangement, there really won't be an empathic responsiveness to the patient. Or, if the therapist doesn't understand the problem. The therapist doesn't grasp what it is that's going on, and doesn't know what to do to help the patient, in terms of regulating all these things ....

The other factor leading to a malignant regression involves the therapist's general lack of understanding about what the patient needs.

This is another form of attunement failure. However, it can result from diagnostic errors which lead to using the wrong technique with a patent. This can involve a failure to understand the structural deficits, and other factors, which predispose some patients to a malignant regression. When the therapist is aware of this potential they must also know what steps need to be taken to contain and avoid the regression. The following passage illustrates these points:

> A factor in the treatment process that would precipitate a [malignant] regression would be either a diagnostic or a therapeutic error. A diagnostic error would include an insufficient evaluation. Insufficient in that the presence of some ego weaknesses or impairments in ego function were not detected. Therapeutic errors in pathological regression are likely to result from a therapist's inaccurate diagnostic formulation and the consequent application of an expressive or uncovering kind of therapy in a patient who lacked sufficient structure and support to manage the inherently regressive pull associated with intensive psychotherapy.

The failures in attunement by the therapist can take many forms. For example, a therapist can underestimate the impact of the uncovering process on the patient. This can lead to a malignant regression as a result of the process getting ahead of the patient's and the relationship's capacity to deal with and contain what emerges.

The therapist's activity level, in either direction, can also precipitate a malignant regression when it fails to meet the patient's needs at that moment. In one example, the therapist's silence was experienced by the patient as a deprivation and abandonment. In another example the therapist's increased activity was experienced by the patient as controlling and intrusive. Both lead to malignant regressions.

In another example, the malignant regression was precipitated by developing the rapport too quickly with the patient. Here there was a lack of attunement to the patient's difficulties and fears around relatedness, and the loss of boundaries. This illustrates how the therapist must be attuned to even the most subtle aspects of the patient's dynamics and process within the context of the relationship. This is especially true with patients who have a low threshold for malignant regressions due to structural deficits.

These patient's will often misinterpret the therapist's actions, leading to an experience of the therapist as recapitulating an earlier failure by a significant object. This usually centers around an issue to which the patient is quite sensitive. Thus, the therapist needs to be aware of it. This is illustrated in the following quotes:

> ... the more disturbed patients ... would ... misinterpret something I said in the session. And, come back or call in a panic almost immediately, and say that I was angry at them, or didn't like them, or I wasn't going to see them anymore. It had nothing to do with any reality that had gone on.

> [With more structurally impaired patients] one [the therapist] will recapitulate the same deprivation that occurred in the environment, or the same empathic failure that occurred before. These are patients that certain things were not provided for. And then, if you ... fail to take into account where they're at, and you miss in terms of attunement and where it is that you need to respond. A lot of stuff will get stirred up again. ... And you will end up being the not good enough therapist, the not good enough mother for these patients ....

The lack of attunement also includes failures in appreciating the patient's role in this process. In many cases, the therapeutic errors reflect a direct response to the interaction with the patient. The therapists indicated how patients sometimes left them with few therapeutic options, and the feeling that the outcome would be negative

no matter what they did. Thus, the patient's dynamics appear to be at work in inviting the therapist into certain errors and failures in attunement. This reflects the dyadic nature of the process.

In most cases, the patient's dynamics operate to set the therapist up to recapitulate the same type of failure which occurred in the past with a significant object. These recapitulations seem to center around experiences of rejection, violation, or abuse with past objects. The patient is usually unaware of this process and their association of the therapist with a past object. This is illustrated in the following example where the patient went into a malignant regression after asking for a decrease in the number of weekly sessions. The patient set the stage for the regression through her request, and the therapist unknowingly recapitulated a past rejection experience for the patient by agreeing to the request. The therapist states:

> Recent example [of a recapitulation of a parental failure], a patient that I've been seeing for twice a week therapy for four years. Because of budgetary constraints, needed to dilute the treatment to once a week. We had discussed the economic ramifications of her life situation, and it seemed to be the appropriate thing to do, although neither one of us was happy with it. In this case, we both agreed that it made sense to meet once weekly until the economic picture improved, which was on the horizon. The patient, although having made the decision after a lot of consultation, felt that I was rejecting her, and didn't want to see her, and was glad to be rid of her. And now, wouldn't have to see her more than once a week because I didn't like her anyway. I needed to remind her, and in that sense bring her back from a regressed state, that it was her own decision based on reality factors.

It appears that patients in a malignant regression often manifest varying degrees of paranoia. Several therapists indicated that many patients who are prone to malignant regression have a paranoid personality structure or dynamic. With these patients there is an

increased potential for the therapist to inadvertently recapitulate a destructive relationship. The patient's past history of having a relationship betrayed or abandoned by a significant object appears to set the stage for a recapitulation of this experience in the present, either through a direct error by the therapist or a misinterpretation by the patient.

The dynamic forces within the interaction between the patient and the therapist are often overwhelming towards precipitating a malignant regression. In the following passage, the therapist indicates that the patient's projective identifications can push them into acting like a past object, and therefore recapitulating the failures of that object. In this case, it becomes necessary for the therapist to contain and transform the projective identifications. This avoids a recapitulation and averts a possible malignant regression. The therapist states:

> The patient comes in, projects this into the therapist. The therapist then behaves in a manner, with the patient, consistent with that which is projected, that's the projective identification. It has to be an object relationship that develops, there's not enough to do it just as a projection. ... the patient and I then are having the same [past] experience that lead to the patient projecting it into me 25 years later. And, if that indeed occurs and I don't put any mid course correction in that ... I will be as pathological to that patient as the significant others were to that patient long ago. And that's where the recapitulation and repeat will be. And my job is to take that which is being put into me, hold it, and then transform it ... and turn it another way.

The recapitulation of past failures, leading to a malignant regression, can result from two types of failures in attunement. One involves a general failure to understand the patient's dynamics and process. Here, the therapist recapitulates the past as a result of general technical and diagnostic errors. The other failure in

attunement involves a specific situational failure in recognizing how a specific piece of behavior or transaction by the patient sets up the potential for the therapist to recapitulate a malignant relationship. Here, the therapist's response meets the patient's expectations for the behavior of significant objects in this situation.

The therapist's ability to neutralize the potential for a malignant regression suggests that the recapitulation process is not malignant. One of the therapists addressed this directly and indicated that the patient's recapitulation of the past reflects an attempt to rework it with a positive outcome. Thus, it may reflect a process which can be utilized in the service of change and progression.

Within this process, it appears that the patient attempts to create, in a very concrete and real manner, a context for reworking a past experience and relationship within the present. It then becomes incumbent upon the therapist to interact with the patient in a manner which does not recreate the malignant role or actions of past objects. Here the patient appears to need an interaction with the therapist which allows for the establishment of a sense of security and safety. Consequently, a malignant regression can be conceptualized as a response to the therapist's recapitulation of a prior negative experience and relationship, at a critical point when the patient was attempting to rework that experience and relationship with the hope of a different outcome.

Therapeutically, this suggests that the therapist may need to do more than offer an interpretation. They may initially need to interact in a manner which avoids a recapitulation of the patient's past. In

some cases, the initial step of an interpretation may be experienced as a recapitulation of an empathic failure by the patient.

All of the therapists indicated that a benign regression can become malignant under specific circumstances. This potential suggests that there is a fine line which separates benign and malignant regression. The therapists identified the nature and strength of the relationship as a critical factor for whether or not a benign regression becomes malignant. This is based on the capacity of the relationship to hold the patient and maintain the controls they need to sustain a benign regression. Often, a negative shift in the patient's experience of trust and security with the therapist can lead to a malignant regression. This is usually in response to some failure in attunement by the therapist. This is conveyed in the next quote:

> Anytime there's a shift in that rapport or sense of security, I think we find instances of brief pathological regression.

The following quote illustrates how a malignant regression can also occur when a benign regression begins to outdistance the capacity of the relationship to maintain the patient's integration and control. In this case the patient has literally lost the therapist. The therapist states:

> ... if either for the needs of the therapist, or the needs of the patient, you begin to forget about the necessity of always keeping the relatedness and the modulation ahead of the regression. ... you can take a positive regression and it can outdistance its coverage and then become frightening. I think some of that happens in every regression. But, if it gets too far away from the coverage, then it can get into a ... negative regression, and activates paranoia. So, no matter how positive the regression is or how kind of loose things get, there always has to be a part of the therapist, and a part of the patient too, attending to, "are we getting beyond our control

mechanisms, are we getting beyond our object relatedness here?" And, if that happens, then it has to be called back ....

The therapist, in the following excerpt, indicates that some patients will become provocative and terminate the treatment when they experience the relationship as unable to contain what is emerging in a benign regression. Where the patient remains in treatment, the therapist's failures in attunement result in overtaxing the patient and the relationship, and the result is that a benign regression becomes malignant. The therapist states:

> It [the benign regression] gets out of control because either I have faulty judgement about the strength of the attachment, or the patient, during the benign regression, sort of falls through their floor. Its like they're at this level and we're working up here but suddenly, for reasons which I don't necessarily understand, they just drop two, three floors to extremely primitive experiences. And, in the process they lose me. ... often times patients who are aware that they may be getting to that point become extremely provocative and terminate the treatment. But I would consider that a treatment failure because whatever it is that they were dealing with, we didn't work it out. And not only that, the relationship, or my technique, or understanding, or whatever was not up to dealing with the intensity of the problem as they experienced it.

In order to avoid a malignant regression, the therapist must monitor the patient's existing controls, as well as their capacity to use the attachment and relationship to maintain integration and control. Often, the controls provided by the relationship serve to compensate for the patient's limited controls as a result of ego deficits. The next quote illustrates the importance of the patient's capacity for attachment in this process:

> I would see a predisposition to pathological regression as an incapacity to make an attachment. Someone who ... does not have the capacity to make an attachment. I'm going to be extremely careful if I'm going to do any regressive work at all, and chances are I'm not going to do any. ... Because the

> thing that I depend on as a therapist to have some control, from the patient's point of view as well as from my own, is I'm sort of a life line if the patient goes reeling out over the edge, and I'm supposed to pull them back. That life line is constructed of the attachment. No attachment, the patient goes over the edge, and he's gone, he doesn't come back. ... some people attach easily and bond very strongly, even if they're crazy.... It's an independent variable. And others who are reasonably intact ... have no capacity to attach.

When a patient enters a malignant regression, there are several steps which the therapist can take to try and reverse the process. They are not always successful, however. The first step involves reestablishing integration and the patient's ego functions and secondary process reality testing. In order to do this, therapists assume a more active role in introducing containment, structure, and reality for the patient. This includes becoming more concrete and focused on external reality, rather than being abstract and focusing on the patient's past or internal state. When a patient is lying down this may involve something as concrete as asking them to sit up or to stand and walk around. These interventions reflect attempts at moving the patient out of primary process and back to secondary process functioning. This is illustrated in the following excerpt:

> I would intervene with reality and tell the patient ... "I can see you're very afraid or concerned about something, you're starting to regress, I want you to stop the regression. I'm not going to hurt you." ... And also, would move to get the person away from very abstract internal issues to very external mundane issues. ... get very concrete, very near future content, and not let things float. And, in this situation I become more active than I would usually in a therapeutic situation. Trying to make the reality of me come through more so they can see what I'm really saying, who I really am, what I may be doing. Make me and everything else more real for them, more concrete for them to slow down that process.

One therapist indicated that an emotional disengagement by the therapist, particularly with paranoid patients, sometimes helped the patient to restabilize and get past the distortions. With some patients medication was seen as necessary in order to reduce the intensity of their agitation and fears, and to reestablish integration.

After the patient and the therapist have gone through a malignant regression, the follow-up work was considered critical to the subsequent course of the relationship and the therapy. An important initial step involves helping the patient to understand what happened, and addressing ways to keep it from happening again. When appropriate, this includes honestly acknowledging when the therapist has made an error. A failure to do this could bring the treatment to a halt. This is conveyed in the following quote:

> It's possible for patients to forgive and for errors ... to be repaired. ... they have to be discussed as errors. ... the therapist has to take some responsibility for the patient going through the regression due to their [the therapist's] limitations, about not understanding. ... And there has to be some debriefing of all that. If there's not, ... it dooms the therapy. ... it builds in a certain emotional collusion and it seals off certain aspects that will never be analyzed in the therapy. The patient will just shut up, shut down, and with good judgement by the patient.

Several therapists indicated that a malignant regression could become therapeutic if it was subsequently integrated into the treatment process, analyzed, and worked through. This requires the continued maintenance of the therapeutic relationship and process, and is illustrated in the following passage:

> [The malignant regression] Can be transformed ... and I'll give you an example with this patient. We're not here yet ... But what I would anticipate occurring with this lady is, this is not the last time that we're going to see this phenomenon

> occur. Hopefully in the future, when it does occur, she'll have some improved ability to reflect on, and recall, and notice that we're repeating something. And that, no matter how intensely she feels it, that there may be other ways of looking at this. When that happens ... it becomes a therapeutically useful regression.

This is not always possible for a number of reasons. One therapist identified the potential for some therapists to abuse the therapeutic relationship by consciously or unconsciously encouraging or allowing the patient to enter a malignant regression. Here the therapist acts out their own sadistic and destructive impulses through the patient. When this occurs, it is not an error which is retrievable due to the severe betrayal of the patient's trust. In this case, the patient is appropriate in terminating the relationship and treatment.

The Therapist's Experiences of the Relationship with the Patient: Regression in General

The data in this section were relatively limited and drawn primarily from one therapist's interview. It remains consistent with the data from other sections. In general, the regressed patient's relationship with the therapist is seen as more primitive. Responses to the therapist tend to be inappropriate, given the real aspects of the relationship. While primitive, the regression is not described as benign or malignant. An example is presented in the following quote:

> ... a fellah who used to see me in Chicago. He lived in Hyde Park. He knew I lived in Hyde Park, he also knew that he was my last patient for the day. So one day, at the end of the session, he said "I don't have any money for the train to get home. Could you give me a ride back to Hyde Park?" I said "no." And he said "oh well will you lend me fare for the Illinois Central?" I said "you know you're acting out." ... he got angry, "of course I'm acting out I'm a patient. If I can't

act out who can act out?" But that kind of primitive dependency, like it was my responsibility to get him home.

The patient's relationship with the therapist is seen as combining both transferential elements from the patient's past, and real elements from the interaction with the therapist. The patient's increasing investment in the relationship with the therapist reflects the emergence of the transference neurosis. The transference neurosis is seen as a specialization of the patient's regression which allows for the working through of the past in the present.

One therapist believes that the regression emerges when the necessary elements have been established in the therapeutic relationship and process, and involves the patient's reliving of past experiences through the transference. The following quote illustrates how the therapist's behavior, within the context of the transference neurosis, serves to precipitate the patient's regression:

> ... there is some precipitant for the patient's regression in the environment. When we're talking about a transference neurosis, it means there's some precipitant for the patient's regression in the therapist's behavior or in the treatment situation.

In one example, the patient's experience of potentially losing the therapist was seen as a precipitant for the regression. The therapist indicated that there were many aspects of the therapist which a patient could experience as lost in the context of the transference neurosis. This ranged from the empathic aspects of the therapist to those aspects which served to support ego functions and maintain control.

While the patient's relationship with the therapist reflects a transference neurosis, the real aspects of the relationship remain

important with regard to the patient's ability to do the analytic work. In the following quote, the therapist states that this involves the patient's capacity to relate empathically with the therapist and to experience the therapist as real and separate:

> ... over the first couple of months of the analytic work, the patient's attention becomes focused on the therapy. ... that tendency to become absorbed in the treatment is evidence of the establishment of a transference neurosis. And, when there is sufficient ... conflictful emotional investment in the therapist, all the major components of their past and their personality structure will get evoked and be examined. One of his [Freud's] original nosologies was to distinguish between the transference neuroses which were treatable and the narcissistic neuroses which weren't. By the narcissistic neuroses ... he meant those patients who were so self absorbed that they couldn't invest enough in the therapeutic relationship and invest enough conflictfully to have the analytic work proceed.

Both the patient and the therapist must also be capable of establishing some distance from the regression in order to examine it. This reflects the ongoing reciprocal process between the patient and therapist which allows for a regression to become therapeutic. When the patient is unable to sustain this process, and is unable to relinquish their distortions of the therapist, then the regression is intractable and cannot become therapeutic.

In the following quote the therapist equates regression with transference. Consequently, regression and transference are seen as universal phenomena which occur naturally in any relationship where there is some emotional investment. The patient's regression in a therapeutic setting is specialized, however. The therapist states:

> The regression in therapy ... is highly specialized. ... patients never, in my experience, lose bowel and bladder control. There's some things they don't forget. ... If you accept that transference means regression. And, if you accept

that transference is ubiquitous, then regression is ubiquitous. The question isn't "does it occur?" The question is "therapeutically what can you do with it?" Second, and this is a common mistake, it's forgetting Freud's distinction between transference, in a specific piece of behavior, and the transference neurosis, which is a characterization of an aspect of the whole analytic relationship. Transference relationships are not ubiquitous. The transference neurosis is specific to the consultation room. Although it probably occurs in other ongoing helper, helpee relationships like couples.

Three Central Themes: Attachment Versus Detachment, Integration Versus Disintegration, and Primary and Secondary Process

Emerging from the analysis of the results, it is possible to identify three central or basic thematic dimensions underlying the therapists' experiences of regression. These experiences can be organized around and understood in relation to the three themes. The first two themes, attachment versus detachment and integration versus disintegration, represent bipolar and mutually exclusive dimensions for functional dynamics. They are tied to the process of the patient's regression. The third theme, primary and secondary process, reflects two modes of experience and functioning which can coexist. This theme deals with regression as a psychological phenomenon.

Attachment Versus Detachment and Integration Versus Disintegration

The therapists repeatedly cited variations along two general dimensions, in differentiating between a benign and malignant regression. These dimensions are captured in the themes of integration versus disintegration, and attachment versus detachment. Integration and disintegration are defined, respectively, as the maintenance or

dissolution of ego structure, ego functions, self structure, and boundaries in the patient and the therapist. Attachment and detachment are defined, respectively, as the presence or absence of a solid bond, trust, and alliance between the patient and the therapist.

While the two dimensions represent distinct continua, they are nevertheless closely intertwined. In many cases, issues of integration versus disintegration are embedded in and contingent upon issues of attachment versus detachment. There appears to be a constant dialogue and interplay between the two dimensions.

The nature of this interplay is notably different for the two types of regression which are invariably represented at opposite ends of each dimension. As dynamic components, the two themes appear to reflect underlying factors which determine whether a regression is benign or malignant within the therapy process.

The patient's ability to maintain control is imbedded in their capacity to maintain integration. In a regression this involves the capacity to remain integrated in response to primary process experiences, and potentially distressing affects which tax the available structure and control mechanisms. When integration is maintained in the face of these factors then controls remain available to deal with what emerges in the regression. This allows for a controlled benign regression.

When integration is lost, this leads to a malignant regression. In general, this involves some form of disorganization and a loss of controls. This can take many forms but is usually characterized by a decompensation in the patient's functioning. This includes losses in

secondary process reality testing and an increase in primary process experiences and potential distortions. In the extreme, the malignant regression involves psychosis with a disintegration or collapse of existing functions, structures, and boundaries.

It is essential to note that the disintegration is seldom complete in a malignant regression. It is not an all or none experience. The patient continues to function in many ways, while experiencing a loss of integration within specific areas. This often involves loses in various types of boundaries, with regard to ego and self structure, and in specific ego functions. This can include impairments in reality testing, impulse control, and judgement. Whatever form the disintegration takes, it is invariably a frightening experience for the patient who appears to be confronted by some threat to their existence.

Patients who experience a sense of impending disintegration manifest this with varying degrees of fear. In some cases patients will attempt to terminate the treatment when the fear emerges. When there is a disintegration experience the patient is generally in a state of extreme panic and terror. At this point, they are often overwhelmed by primary process fears of annihilation and the permanent loss of their existence. Secondary process functions are severely impaired and not fully functional. This is the time when patients function purely on survival instincts, relying on old, automatic, and sometimes primitive modes of functioning in an attempt to regain integration.

Externalizing defenses, with the projection of anger and rage, are often employed by the patient in order to reestablish integration.

This is accompanied by distortions of the therapist, who is experienced as the cause of the patient's affective distress. The distortions often recapitulate, with the therapist, the patient's past relationship with a destructive or malignant object.

The capacity to maintain integration in a regression appears to be a function of two major factors. One is the patient's existing level of ego and character structure. The more intact the structure, the greater the likelihood that integration can be maintained by the patient in the face of primary process experiences and emotional stresses. With increasing degrees of structural vulnerability, the greater is the risk for the patient to have a disintegration experience. Thus, structural factors play an important role in the patient's capacity to maintain integration in a regression.

The other major factor involves the nature of the patient's relationship with the therapist. The strength of the relationship can vary from a solid attachment to a state of detachment. The strength of the attachment generally determines the patient's willingness to accept the therapist's management and control of the regression. When the attachment is in place, the therapist is available to assist in maintaining the patient's integration. The therapists' experiences consistently indicate that a solid attachment is necessary in order for a benign regression to take place.

When there is a breach in the relationship, with some degree of detachment between the patient and the therapist, then a malignant regression can occur. Malignant regressions do not occur when there is a solid attachment which remains intact. This accounts for why

malignant regressions often occur early in the treatment before an attachment is formed. Benign regressions do not occur when there is a significant degree of detachment between the patient and the therapist. This accounts for why patients do not enter a benign regression until they are well into treatment and an attachment has been developed. Therefore, the relationship, in the form of the attachment, is also critical in determining whether the regression is benign or malignant.

The degree of attachment which develops between the patient and the therapist is tied to several factors. Initially, the patient must have an existing capacity for attachment, based on their object relations history, in order to form an attachment with the therapist. Without this, no attachment can be developed in the therapeutic relationship. As a dyadic process, the therapist must also have the capacity for an attachment, as well as the capacity to maintain integration.

Given a capacity by the patient to attach, it is then incumbent upon the therapist to establish a sense of security and trust within the relationship. This is primarily the result of the therapist's ability to maintain an attunement to what the patient needs in the treatment, and then to consistently and dependably take the right steps to meet these needs in a therapeutic manner so that the patient feels safe and protected.

Where there are failures in attunement leading to technical errors, then there are potential breaches in the attachment. In many cases these errors recapitulate, or are experienced in a manner similar to previous failures by a significant object from the patient's past.

When this occurs, there is a potential for a malignant regression. Where the attachment is strong enough to tolerate any errors by the therapist, then there is a potential for a benign regression.

The therapists' experiences indicate that despite all other considerations, a benign regression is only possible when two factors are present. An attachment must exist between the patient and the therapist, and the patient must be able to maintain integration prior to and within the regression. This is what allows a patient to have a turbulent regression, which is descriptively and experientially similar to a malignant regression, but still benign. The attachment and sufficient integration are both maintained.

Malignant regressions are possible when there is a state of detachment between the patient and the therapist. This is usually, but not always, accompanied by overt experiences of disintegration by the patient. There are some instances of malignant regression where the patient can still maintain some integration, but generally at the expense of the relationship and the attachment to the therapist. This is illustrated in the two types of malignant regression cited by the therapists where the patient maintained an overt level of integration.

Where mechanisms of projective identification were operating, the patient's disintegration fears, in the form of annihilation fears, were projected into the therapist. Here, the therapist was the arena for the experience of disintegration. If the therapist had not been able to make the necessary adjustments in the relationship and attachment, there most likely would have been an increasing degree of detachment in

the patient leading to a termination, or to an overt disintegration in the patient's functioning.

In the second case, the patient's creation of a false sense of merger and fusion with the therapist served to avoid any real attachment. Speculatively, this may have been a defense against the potential for disintegration. The therapist indicated that if this was not corrected, the absence of a real attachment would lead to subsequent problems in the therapy process. This could include a premature termination when the patient experienced the real aspects of the therapist as less than ideal. Speculating again, this could also lead to a disintegration experience and an overt malignant regression by the patient. Thus, issues of detachment and disintegration appear to be evident in some form in all types of malignant regression.

In contrast, benign regression is consistently characterized by the patient's sense of attachment and maintained integration in the therapy. This is a shared experience, reflecting a parallel process where the therapist also feels that the relationship is intact, and the regression is under control. This is not true in a malignant regression. Here the therapist tends to feel affectively distressed and out of control along with the patient. The therapist experiences the patient as detached, with a disintegration in ego functioning and boundaries. Here the relationship is fractured and the patient is out of control.

The therapists' interventions and maneuvers, in response to each form of regression, also reflects the two themes. In terms of working towards a benign regression, much time goes into developing the

attachment with the patient and assessing, or establishing where necessary, the structures which will maintain integration for the patient. When a regression is malignant, the management involves reestablishing integration and control and the real aspects of the relationship and the attachment.

With a benign regression, the therapist works to maintain the attachment and the patient's integration. This includes keeping the regression within the strength of the attachment. The therapist's capacity to manage the regression and maintain the patient's integration is embedded in the strength of the attachment. The attachment serves as a stabilizing force, which is particularly important when the regression starts to go awry and confronts the patient with the potential for disintegration. It allows the patient to continue working in collaboration with the therapist in order to reestablish integration. Consequently, integration can be maintained when the patient is unable to do this independently.

Without an attachment, or when there is a severe break in the attachment and when things go awry, the patient will generally fall back on themselves to get things right. Where they have little capacity to do this, as a result of structural or other factors, disintegration and a malignant regression generally ensues.

The therapists indicated that regression generally allows for a reworking of the past in the present. However, this can only occur when the regression remains benign. The stronger the attachment and the more integrated the patient feels, the deeper is the benign

regression. This allows for the regression to access pretraumatic states for some patients.

The outcomes for a benign and malignant regression are also represented in the two themes. The therapists indicated that the results of a benign regression reflected positive changes in self and ego structure and functioning, including improvements in the patient's capacity to maintain ego, self, and boundary integration. Improvements were also seen in reality testing and secondary process functioning, with more adaptive access to primary process. Interpersonally, there were enhancements in the quality of the patient's attachments and relationships.

With a malignant regression, if no subsequent therapeutic changes occur, the outcome is a recapitulation of past failures for the patient, and a reaffirmation of how attachments cannot be relied upon. This is presumably accompanied by an enduring underlying fear of disintegration in the face of failures by significant others. The malignant regression can become therapeutic and lead to changes, but only if the patient is able to subsequently establish or reestablish an attachment and maintain integration.

Most of the therapists conceptualized regression as a unitary phenomenon, where benign and malignant regression are represented at opposite ends of a continuum. The various combinations and degrees of attachment and integration or detachment and disintegration lead to the different types of regression along this continuum. The interactive nature of the two dimensions is overtly illustrated in situations where

a benign regression becomes malignant. This also demonstrates the fine line between the two types of regression.

Primary and Secondary Process

The therapists consistently described an observable shift in the patient's level of consciousness and cognitive functioning when they entered either a benign or malignant regression. These changes were identified as a shift from reality oriented secondary process functioning towards more idiosyncratic, primary process functioning. A regressed patient was seen as manifesting more primary process modes of functioning and experiencing, with an apparent reduction in secondary process functioning.

This shift appears to be a central and essential aspect of all forms of regression. As a central dynamic, the shift from secondary to primary processes supports the conceptualization of regression as a unitary phenomenon. The nature and dynamics of the shift differ, however, for the two types of regression. Variations in the balance between primary and secondary processes were repeatedly cited by the therapists in differentiating between benign and malignant regression.

The shifts between secondary and primary processes were not described as an all or none phenomenon in a benign regression. While primary processes became more evident, the patient's secondary process functioning was also maintained. However, its role was less figural and no longer dominated the patient's consciousness.

The shift between processes in a benign regression appeared to represent a figure and ground reversal in which the regressed patient's

primary processes became figural relative to their secondary processes. What is essential is that both modes of functioning coexist in a harmonious balance within a benign regression. The therapists indicated that the shift to primary process modes of experiencing and functioning was controlled and generally contained within the sessions. In general, it did not severely impair the patient's daily functioning.

Within the sessions, patients in a benign regression were often seen as internally preoccupied, with a diffuse or nonfocal cognitive quality. The shift into primary process also resulted in perceptual distortions and increases in affective experiences and expressions. This often resulted in the patient having preverbal, primary process types of affects, memories, and experiences which were difficult to verbalize. Content often involved important issues from the patient's developmental past, usually in relation to significant figures.

A recurring indicator of the regression, and the effects of primary process functioning, was the distortion in the patient's time sense. In a benign regression this often involved an acceleration in their experience of time so that sessions passed quickly.

The patient's capacity to enter into and make therapeutic use of primary process experiences in a benign regression is a function of the integration and attachment factors discussed earlier. Within the attachment, both the patient and the therapist must willingly agree to accept the primary process experiences and functions. Structural factors alone were not sufficient for this to occur. Some patients who were structurally intact were still unable to allow a shift into primary process due to a lack of trust. In some cases, structurally

less intact patients were seen as more willing and able to enter into primary process experiences within a controlled interaction with the therapist.

Several therapists indicated that primary process should not be directly equated with primitive levels of functioning. They conceptualized primary process as another type of organization relative to secondary process functioning. It was also suggested that primary process continues to develop along with secondary process and therefore plays an important role in the individual's functioning throughout their life. One of the outcomes of therapeutic change was seen as a greater flexibility in accessing and using primary process functioning to enhance adaptive functioning.

Conceptually, this indicates that primary and secondary process should not be categorized into lower and higher modes of functioning, respectively. These modes of functioning coexist and interact, but the process of this interaction is not always evident. In a regression, the primary process modes of functioning become figural, and therefore their effects on the person's functioning become more evident.

In a malignant regression, the immersion in primary process was seen by the therapists as frightening and often terrifying for the patient due to accompanying losses in control and integration. The metaphor of a nightmare was offered to convey the patient's experience of being affectively inundated and terrified over a sense of total helplessness in the face of impending doom and annihilation.

In this case, the secondary process functions were reduced or unsuccessful in mitigating and titrating the affects and experiences

which patients had in a malignant regression. Thus the primary process functioning became figural and dominant without the secondary processes maintaining a significant role in the background. This resulted in the patient's reality distortions remaining fixed. Interventions were consequently directed at reinstating secondary and external reality oriented processes.

The emergence of primary process functioning and experiences in a malignant regression was not seen as problematic in itself. The primary process experiences were therefore not inherently malignant. The patient's lack of controls, loss of secondary process functioning, and experience of disintegration in the face of these primary process experiences was the real problem. Thus, where subsequent integration and control could be established within the therapeutic relationship and process, the primary process experiences could become useful and therapeutic.

While patients are regressed and immersed in primary process, the therapists reported often having experiences which paralleled the patient's experiences. With patients in a relatively tranquil benign regression, therapists reported also having pleasurable primary process experiences. With a patient in a malignant regression the therapists' experiences were often dominated by intense affects which were sometimes terrifying for them, just as they were for the patient. This was often accompanied by experiences of being overwhelmed and helpless to extricate themselves or the patient from the malignant regression.

While primary process functioning and experiencing assumes a figural role in a patient's regression, it was not equated as a synonym

for regression by the therapists. The shift and resulting balance between secondary and primary processes appears to reflect the fundamental nature of regression as a psychological phenomenon. As a process, the balance between primary and secondary processes appears to be tied to issues of attachment versus detachment and integration versus disintegration.

CHAPTER V

DISCUSSION

Introduction

Eight therapists were interviewed, and their experiences with patients in benign and malignant regressions in psychotherapy were described and thematized, resulting in three central themes. The first theme, attachment versus detachment, reflects the presence or absence, respectively, of a solid bond, trust, and alliance between the patient and therapist. The second theme, integration versus disintegration, reflects the maintenance or dissolution of self and ego structures, functions, and boundaries in the patient and therapist. These themes were tied to the process of a regression in psychotherapy. The third theme, primary and secondary process, involves two coexisting modes of experiencing and functioning which define regression as a fundamental psychological phenomenon.

The therapists' experiences indicate that benign and malignant regressions represent opposite points along a continuum for what appears to be a unitary phenomenon. Given the themes, a patient's regression in therapy is benign when a therapeutic attachment and ego integration are maintained, and secondary process functions remain operative in the background while primary process experiences become figural. When there are instances of detachment and disintegration present, with a loss of secondary process functions in relation to primary process, then the patient's regression is malignant.

In general, the therapists portrayed regression as a natural and ubiquitous phenomenon which was present in many forms within everyday functioning as well as in psychotherapy. For example, one of the therapists in the study states:

> ... I think regression, and the experience of regressive forces are an aspect of daily life.... I think that regression is a unitary phenomenon which occurs in essentially the same form in all people.

Regression was also seen as a natural mechanism for change and growth through a reworking process which begins with patients reexperiencing or recapitulating past relationships and events in the present. These primary process experiences then become directly available to be reworked.

While the use of regression by therapists offers the potential for significant therapeutic change the results indicate that it has often been avoided rather than courted within the therapeutic process. The results also suggest a general misunderstanding by many therapists about the nature of the patient's regression, as well as conscious and unconscious fears by therapists about the phenomenon. While the unconscious fears cannot be resolved here, the discussion presents a detailed overview of the therapist's experiences of the patient's regression which integrates the experiences of the therapists in this research, the literature, and the researcher's views.

Regression as a Clinical Process in Therapy

Within the psychotherapy process there appear to be several interactive factors which determine whether a benign or malignant

regression will occur. These factors determine whether the patient's attachment to the therapist, their ego and self integration, and their secondary process functioning are maintained or lost in the therapy process and regression. The discussion of these factors will begin with a consideration of the patient's ego and self structure.

Structural Factors

Based on the therapists' experiences in the present study and the literature, it appears that the patient's past experiences, in terms of object relations and early traumas, are retained and represented within their ego and self structure. Thus the effects of the past, either positive or negative, are continually manifested in the present.

The results of the present study indicate that the patient's past experiences and heredity contribute to the development of their structural integrity. The structure then determines whether functions like reality testing, judgment, impulse control, and self and ego boundaries are maintained at an adaptive level.

The results indicate that the patient's developmental past, which has become integrated into ego and self structures, establishes their potentials and capacity to maintain integration versus disintegration prior to and during a regression. Current environmental and relational factors are also critical to the process and will be discussed later. The patient's capacity for attachment versus detachment also appears to be represented structurally and is therefore manifested in the same manner in every relationship. Consequently, structural factors constantly and directly determine the patient's potential for benign or

malignant regression, and the course of that regression. For example, one of the therapist's in the present study states:

> ... the form a regression takes varies in terms of its primitiveness and potential for actively disrupting a person's life and level of functioning. The primary factor in determining how severely a person's functioning is affected is the level of development that they have attained in their life or, the level of characterological structure.

The results of the current study also indicate that all patients are vulnerable to malignant regression under specific circumstances, although the potential is greater for more structurally impaired individuals. However, not all individuals are capable of a benign regression. These findings are supported in the literature (Calder, 1958; Frosch, 1967; Joseph, 1965).

Balint (1968) focuses on the importance of structural deficits, which he describes collectively as a "basic fault", in relation to regressive potentials. He believes the patient's potential for disintegration and a malignant regression is directly related to the severity of the structural fault. The origin of the basic fault is tied to the earliest dyadic relationship and what Balint calls a "lack of fit" between the infant's needs and the maternal care.

Guntrip (1969) takes a similar position, indicating that the various splits in the ego represent structural elements which exert an enormous pull on the individual towards intrapsychic disorganization. The fragmenting of the ego results in an enduring, structural "ego weakness" which interferes with the development of a sense of wholeness and ego integration, leaving the individual continually fearful of ego disintegration and vulnerable to malignant regression.

For Guntrip (1969) and Balint (1968) the only means of healing structural deficits was though the process of a benign regression. Kris (1975) indicates that structural factors are also important in determining the patient's capacity to maintain integration within a benign regression. Winnicott (1954b/1975) also indicates that an "organized" or benign regression is only possible when the ego has achieved some integration and complexity in its organization, including the development of an observing ego which can be maintained within the regression.

While a simple linear relationship does not exist, the results and literature indicate that patients with more integrated, stable, and intact structure tend to have less difficulty maintaining integration within a benign regression, relative to more structurally impaired patients, and tend to be less prone to malignant regressions.

While patients with less intact ego and self structure tend to be more vulnerable to malignant regressions, the results indicate they are able to enter benign regressions when a sufficient degree of internal structure, and the necessary external and relational conditions are present. Due to their structural vulnerabilities, these patients often have more turbulent regressions relative to more intact patients. It appears the interaction between structure and environment is most critical with structurally impaired patients whose functioning is more directly affected by external factors. For example, more structurally impaired patients often require more support from the therapist in order to maintain integration in a benign regression.

The results also indicate that a patient's capacity to maintain integration and secondary process functioning does not necessarily mean a benign regression is possible. Structurally more intact patients may be less accessible to a benign regression due to their rigidity and avoidance of primary process experiences. Any difficulties in forming attachments will also seriously interfere with the capacity to enter and sustain a benign regression. Thus, structure is not the final determining factor for a benign regression but does set the stage for it and the course it will take.

Relational Factors

While structural factors appear to establish the initial potentials and thresholds for benign and malignant regression, relational factors may directly determine whether these potentials are actuated. The therapists' experiences in this research indicate that the degree of attachment versus detachment between the patient and the therapist directly affects whether a regression is benign or malignant. Here it appears that the patient's current interpersonal experience constantly interacts with their past experiences which are structurally represented in the present.

The results of the present study indicate that an attachment between the patient and the therapist initially requires an established capacity for both parties to make such an attachment. All subsequent relational developments affecting the process of a regression depend upon the patient's capacity to attach making it a critical factor. Without the capacity to attach a benign regression is not possible. An

inability to attach also poses an increased potential for malignant regression. The importance of the attachment in a benign regression is conveyed in the following quotes by two of the therapists in the current study:

> First of all, you have to have a stable attachment [for a benign regression to occur]. That there's a working alliance between you and the patient.

> Therapeutic regression is a process that can only occur within the context of a sound therapeutic relationship. Can only occur when the patient and the therapist have been able to establish a real therapeutic alliance. I don't think a patient is going to regress in a treatment unless he or she has a great deal of trust in the therapist.

With a capacity to attach, the patient's attachment then appears to be built upon a sense of security and trust with the therapist. The patient's trust appears to develop in response to the therapist's ability to remain attuned to the patient's needs, and to then act appropriately in dealing with these needs. The ability to actively respond to what the patient needs is particularly important with structurally impaired patients.

Essentially, this process involves what Winnicott (1960b/1965) refers to as "good enough mothering" based on a "primary maternal preoccupation." The preoccupation is basically a regression which allows the mother greater access to primary process functions and experiences which enhance her response to her infant's emotional state and needs. Direct parallels between the mother and her infant and the therapist and their patient, respectively, have been drawn in both the literature and in the results of the present study, and will be developed in this discussion.

The mother's preoccupation or attunement allows her to be highly sensitive and responsive to the infant's gestures and needs. For Winnicott (1960b/1965) the mother's attunement leads to her responding consistently and appropriately to her infant's needs, resulting in the infant feeling held by a reliable and dependable object. When the mother's attunement is maintained, a healthy sense of ego relatedness and trust is established, allowing for ego growth and integration to proceed. However, with repeated failures in attunement and attempts to meet her own needs rather than the infant's, the mother is not experienced as reliable and dependable resulting in a faulty attachment and inadequate ego integration. The importance of the therapist's attunement is conveyed in the following quote by one of the therapists in the current study:

> I do think it's the attunement that the therapist has with the patient that creates the possibilities for the regression to be positive or negative.

The following section of the discussion is an integration of the results of the present study and the literature. When a patient enters therapy, their object relations history and resulting structure appear to create a template for their interaction with the therapist. As transference, this template reflects a natural recapitulation process in response to aspects of the therapist which evoke experiences with past objects. The recapitulation process is generally unconscious and reflects brief episodic regressive experiences of positive and negative aspects of previous relationships and events. Speculatively, there are probably many "micro" regressive experiences or shifts into primary process which are either benign or malignant.

The recapitulation process appears to be neither benign nor malignant, but offers the potential to rework the past in the present through the therapeutic relationship. This potential appears to depend upon the ability of the therapist to maintain attunement and avoid fully recapitulating the failures of a past object.

The results of the current study indicate that the recapitulations of previous positive relationships and attachments are important as anchors for the development of an attachment between the therapist and the patient. A benign regression is not possible if the patient has never had such a relationship before. Where the positive transference is idealized and represents a splitting process rather than a real attachment, the therapist must alter the idealization to develop a real attachment. The importance of the patient's early positive relationships in a benign regression is illustrated in the following quote by one of the therapists in the present study:

> The biggest factor for a benign regression that I've found is that in someone's developmental history, if they had some significant experience with a positive object relationship ... I find that if something did in fact happen that was positive, that they can have an anchor point or a memory that something good can take place between people. If its in there somewhere, and often there can be very negative relationships all around it. But, if it never happened to a significant degree with the person, then to have a benign regression take place is almost impossible.

The results of the present study and the literature consistently indicate that in order to develop the degree of attachment necessary to support a benign regression the therapist must repeatedly transform the patient's negative recapitulations by providing a therapeutic response which is different from the patient's original experience. The process

requires the therapist to maintain attunement and follow the patient's process so the patient feels held like the infant receiving good enough mothering. In order to develop the attachment and trust Balint (1968) believed the therapist should provide what was lacking in the patient's primary relationship, in terms of sensitivity, awareness, and empathy, through the creation of a therapeutic environment. As a result, the positive, real aspects of the relationship with the therapist displace many of the potential negative distortions from past relationships.

Thus, it appears that the therapist's response to the patient should extend beyond a secondary process interpretation and should involve a specific interpersonal response which deals with what the patient needs therapeutically at that particular moment. Consequently, the therapist can avoid potential malignant recapitulations and quickly neutralize those which emerge on an incident by incident basis initially. Therefore, the benign regression appears to be the product of a well developed relational pattern between the therapist and the patient.

In establishing the relationship there appear to be many brief, micro benign regressions which precede a full benign regression. Therapists can often observe episodic benign regressions following an intervention that makes the patient feel held and secure, and thus recapitulates the positive aspects of a previous relationship. Brief benign regressions are often reflected in the patient becoming more childlike or dependent, with positive affect, silliness, laughter, and even physical responses often associated with a contented child.

In a benign regression, which the therapists in the present study identified as an ongoing process, the reworking appears to be maximized since the positive aspects of the therapeutic relationship are assimilated more completely resulting in a displacement of aspects of earlier negative relationships. Consistent with the results, Balint (1968) believed that the patient must be allowed to regress and develop a new object relationship with the therapist in order to heal the structural fault.

According to the therapists in the present study, a benign regression is usually heralded by the patient's increasing internal preoccupation, which involves a focusing inward on events from their interpersonal past with a parallel decrease in their external reality focus. The shift away from external reality seems to indicate that the patient is ready to relinquish control, and trusts that the therapist can maintain the controls, integration, and secondary process functions for them while they move into primary process experiences. The importance of the therapeutic relationship in this process is conveyed in the following quote by one of the therapists in the study:

> I think that this is the sine qua non of benign regression. It has to be in a safe interpersonal context in which the therapist is willing to take responsibility for whatever it is that comes up. In that sense, it is a recreation of a parenting kind of ambiance in which one person takes responsibility for someone else. With that kind of ambiance people regress while they're wide awake and it is controlled.

A metaphor used by one of the therapists in the Results section aptly applies here. The patient's trust within the attachment to the therapist establishes a "life line" between them which allows the patient to feel that the therapist will literally reel them back to

safety should they begin to experience any sense of disintegration in a benign regression. The life line allows patients with more severe structural deficits to enter a turbulent and distressing regression which remains benign.

Sharing control with the therapist apparently allows the patient to become preoccupied with primary process experiences without the need to actively and directly maintain the dominance of secondary process functions. In order for the patient to enter a benign regression they apparently need to feel that their external boundaries are relatively secure and no longer need full attention. Consequently, the patient can attend more directly and completely to internal affairs.

Given this process, the therapists in the present study indicated that the potential for benign regression is always present for most patients but can only be accessed when the necessary structural and relational factors have been established. Benign regression is not simply an encapsulated regression within the therapy session, but an ongoing process which allows for flexible and controlled shifts between secondary and primary process. Thus, a benign regression represents the attainment of a steady state of flexible, controlled shifts.

The results indicate that the process of a malignant regression involves some failure by the therapist to take the patient's negative recapitulations and rework them, leading to the experience of detachment by the patient. Like the infant whose mothering is not good enough, the patient experiences the therapist as unreliable and undependable due to failures in attunement. Repeated failures to neutralize and rework the patient's negative recapitulations will

severely impair the development of a solid attachment and possibly terminate the therapeutic process. The role of the recapitulation process in the therapy is illustrated in the following quote by one of the therapists in the study:

> There would be, with the therapist, a recapitulation of that which they [the patient] have constructed and experienced before in their past life... then the regression will be malignant.

The results of the present study indicate that the role of the patient's ego and self structure now becomes important in relation to the therapist's attunement failures and recapitulations of the malignant aspects of past relationships. With patients who are structurally vulnerable to disintegration and the loss of secondary process functions, the therapist's failures can lead directly to a malignant regression. Here the initial primary process distortions have not been contained, or modified by the therapist but inadvertently allowed to unfold. Thus the therapist is experienced as if they were a malignant object from the patient's past. The patient then appears to unconsciously act out with the therapist the same interaction which they once had with the earlier object. The severity of the malignant regression at this point is variable and dependent upon the interaction between structural and relational variables.

With structurally vulnerable patients this process can occur very quickly and often at the outset of the therapy before an attachment has developed and the more real, positive aspects of the therapist have become figural for the patient. However, a malignant regression is possible at any time with any patient when the attachment is breached

and the patient loses integration and their secondary process functions while immersed in primary process. Thus, a benign regression can become malignant when these conditions occur, even with patients with relatively intact structure.

The hypothesis. It is now possible to explore the hypothesis presented in the Literature Review in light of the results obtained from the therapists' experiences. The hypothesis focuses exclusively on the nature of the therapeutic relationship which is considered critical in determining whether a regression is malignant or benign in psychotherapy. According to the hypothesis a critical period is reached in the course of the therapy which calls for the therapist's acceptance of the patient's need for a regression to a state of infantile dependency. The hypothesis suggests that the dependency needs are often embedded in and obscured by the patient's process of recapitulating the failures of previous parental figures with the therapist. It is assumed that the development of the attachment with the therapist would most likely activate the previous failures of attachment figures.

The hypothesis presents three possible outcomes resulting from how the therapist responds to the patient. When the therapist fails to respond to the patient's needs for regression to dependency, but does not fully recapitulate the failures of earlier objects, the benign regression is aborted but a malignant regression does not occur. Here the patient's involvement in the therapeutic relationship is maintained with the hope of having their dependency needs eventually met. When

the needs for regression to dependency are not met, and the therapist recapitulates the failures of earlier objects, a malignant regression usually occurs. However, when the needs for regression to dependency are met without recapitulating past failures, the potential for a benign regression is established.

The hypothesis is partially consistent with the experiences of the therapists in the current study. The results indicate the importance of relational factors and the therapist's role in actively negotiating the patient's recapitulations of earlier negative relationships in order to court a benign regression and avoid a malignant regression. The focus on one critical point in the therapy is simplistic, however, since there appear to be many points which must be negotiated throughout the course of the therapy.

The results, however, do not fully attest to the hypothesized importance of the patient's dependency needs. Two therapists in the research indicated that the process involved the patient's dependency upon the therapist, but the other therapists did not. However, the results do indicate the need for the therapist to fully accept and participate in the patient's movement into a benign regression, and the importance of remaining attuned to the patient's needs in general. It appears that in a benign regression the patient becomes increasingly dependent upon the therapist's attunement in maintaining the attachment and their integration, even if the dependency does not reflect an infantile state.

It is assumed that the first of the three options outlined in the hypothesis occurs often, where the regression is thwarted but the

attachment is maintained. In this situation the treatment continues with maintained secondary process dominance, but without the potentials for a shift into a benign regression.

While the primary, infantile regression to dependency addressed in the hypothesis is not fully consistent with the results, support can be found in the literature. For example, Ferenczi (1949) compares the patient's regressed state in therapy to childhood and a "complete lack of will" (p. 238), when the infant is completely dependent.

Balint (1968), Ferenczi (1949), Guntrip (1969), and Winnicott (1954a/1975; 1960a/1965) indicate that when a secure therapeutic environment is maintained the patient can regress in a controlled manner to an earlier state of dependence which maximizes the process of assimilating and internalizing new experiences. Winnicott (1954b/1975) directly identifies benign regression as an "organized return to earlier dependence" (p. 291) which parallels the early infant-mother relationship. Ferenczi (1949) indicates that patients can regress to a level which parallels a developmental period of early dependency called the phase of "passive object-love" characterized by the wish for total and unconditional love within a dependent relationship.

Guntrip (1969) states that the goal of a benign regression is to allow the patient to reexperience their primary dependency needs within the relationship with the therapist. The regression can then be used to change the effects of early parental failures. Here patients are seeking to obtain good enough mothering within the therapeutic relationship. Guntrip states that the therapist must be willing to accept the patient's dependency needs while providing what is necessary

for independence. Accepting the dependency does not involve granting the patient complete and unconditional gratification, but accepting the role of maintaining attunement and the security of the environment for the patient. Guntrip's position is consistent with the hypothesis.

Regression as a Clinical Phenomenon in Therapy

In addressing regression as a clinical phenomenon two broad areas of focus can be identified. These areas or themes involve shifts between secondary and primary process, and the emergence of past or earlier modes of functioning and experiencing in the present. While addressed separately, these themes are not independent of each other.

A Theoretical Formulation of Primary and Secondary Process

Primary and secondary processes were seen as different and opposite modes of organization by Freud (1900/1965). Secondary process was a means of organizing consciousness through logical thought and was directed at managing and negotiating the individual's external reality and internal id and drive demands. Primary process organized the unconscious and operated by the mechanisms of condensation, displacement, and symbolization; it predated and did not develop along with secondary processes. Thus the primary processes contained primitive and infantile wishes, impulses, and drives frozen in time.

Freud's (1900/1965) initial formulation is not tenable given the results which suggest that primary processes continue to develop along with secondary processes and are therefore not always primitive or infantile. Therefore, another formulation of primary and secondary

processes is offered which draws on the work of Noy (1969). Most of Noy's reformulation is consistent with the results of the present study and is therefore useful in understanding what happens when a regressed patient undergoes a shift from secondary to primary process modes of functioning.

Noy proposes that along with secondary process functions, "primary processes are constantly changing and developing" (p. 158) like all other mental functions. He accepts Freud's operations for primary process involving condensation, displacement, and symbolization, but offers that the patient's "level of functioning and performance constantly develops and improves" (p. 158). For example, the dreams of an adult are usually more complicated and abstract that those of a young child.

In parallel with secondary process, Noy attributes a synthetic and integrative function to primary process which is also involved in the assimilation of experiences. For Noy, these operations are all within the sphere of the ego.

While primary and secondary processes share similar synthetic and integrative functions their aim and purpose in the psychic functioning of the individual are quite different in terms of the their realms of application. Noy believes the secondary processes are reality oriented while the primary processes are self-oriented or self-centered. The former relies on constant feedback, while the later is independent of feedback. Noy (1969) states:

> The primary processes are used by the ego for all the functions aimed at preserving self-continuity and identity and assimilating any new experiences and lines of action into the

> self-schema. The secondary processes are used for all functions aimed at encountering reality and for inner integration and mastery which is done in relation to reality (p. 162).

Noy also makes an important distinction between mental contents and functions. While primary process contents can remain constant and unchanged, primary process functions are continually changing and developing as long as other functions continue to develop in response to environmental factors. Noy also indicates that not all primary process functions or contents are unconscious since both can become conscious.

Primary process functions are seen as subjective by Noy, and deal with the individual's affective state in relation to the self. In contrast, secondary process functions are relatively objective and logical and directed at external reality. For the infant, primary process experiences lead to the existence of objects always in relation to the self in terms of "'doing' something or providing some satisfaction" (Noy, 1969, p. 168).

Primary process experiences are seen as representational and affective. Primary process memories involve a reliving of past experience. In contrast, secondary process experiences are conceptual and abstract. Secondary process memories are cognitive and mediated by words or linguistic symbols.

Noy attributes to the primary process functions the operation of assimilating the earliest affective experiences into schemata. These experiences are then the basis for the formation of the self. Noy (1969) states:

> ... primary process organization is characterized by assimilation of any new experience and its memory into schemata determined by an affective state. Any such schemata is a conglomeration of percepts, actions, and memories in terms of an affective state, and so consist of an organizational unit which may also be called an 'experience'. These 'experiental' schemata are the first cognitive units which later develop and unite to create the 'self' as an entity separated from the environment (p. 169).

Noy states that the secondary process functions deal with changes in reality and therefore involve exact differentiations in time between the past, the present, and the future. In contrast, primary process functions are free of any time limitations or constraints since their task of assimilating new experiences into the self involves the "integration of present with past in order to safeguard the future, an activity which has to transcend any limits of time" (p. 176).

As secondary processes develop Noy believes the primary processes are separated into two general categories. A large body of primary process experiences remain unintegrated and outside the sphere of the secondary and reality oriented processes. These are experiences and functions which remain outside of the demands of reality for adaptation to the constraints of time, space, and causality. They remain egocentric and serve to organize experiences only in terms of the self, independent from external reality. The smaller category of primary process experiences and functions becomes progressively integrated into consciousness and available for use like any other ego function. Noy assigns to this category "... the specific artistic talents and various other special abilities stemming from primary processes" (p. 174).

For Noy, both secondary and primary processes serve essential functions as they develop in tandem. Consequently, primary processes

are not considered lower level functions relative to secondary processes. Healthy functioning requires the operation of both. The continued development of the primary processes serve in maintaining self-continuity while developments in the secondary processes serve to maintain the constancy of the self in relation to the external world. Disturbances in either function lead to psychopathology.

The Roles of Primary and Secondary Process in Regression

Building upon the results of the current study and the work of Noy (1969), this section will present the researcher's theoretical formulation of the nature, function, and operation of the primary and secondary processes in regression. Using a term from phenomenology the primary process experiences will be referred to in this discussion as the "lived experience." The "lived experience" embodies the original experiences of the individual which have remained in primary process form without conversion into secondary process. The secondary processes will be referred to as the "observed experience", reflecting the affective and experiential detachment and mediation which Noy and others have attributed to them.

It is assumed that the primary process experiences represent whole lived experiences which include affects, feelings, ideas, perceptions, sensations, etc. without any meditation, abstraction, or distancing. Thus, these experiences remain pure and timeless. In contrast, it is assumed that secondary process distances the individual from their lived experiences in order to cognize and conceptualize the experience in relation to reality factors. Both processes are essential and

omnipresent in the individual's functioning although the operation of the primary processes are often nonfigural and outside of awareness.

It appears that the shift from secondary to primary process functioning in a regression, which was reported by the therapists in the current research, results in previous experiences becoming figural and accessible as lived experiences rather than just observed experiences. For example, in a benign regression the patient can relive the experience of being a frightened three year old child; they are not simply recalling this experience but they are actually in it.

It is assumed that the earliest lived experiences tend to be more global, less organized, and often more affectively saturated relative to later lived experiences due to the developmental level of the primary process functions at that time. Thus the nature and quality of the lived experiences can vary significantly both within and across individuals.

The depth of the regression also appears to affect how complete the experience is. Within a deep regression patients can reexperience many aspects of earlier lived experiences. For example, a patient can feel like their body has shrunk to the size of a three year old.

It is assumed that in a benign regression the two processes continue to work in tandem even though the primary processes become more figural. The coordinated activity is essential for a regression to remain benign. Even when the individual is not regressed and the primary processes are not figural there appears to be a constant interaction with the secondary processes. It is assumed that the

secondary processes are tied to the individual's ego structure while the primary processes are tied to their self structure.

The secondary processes appear to enhance the individual's functioning by providing mechanisms to deal with deficits in the self structure including the deployment of defenses. Consequently, the constant operations and effects of the self structure upon the individual's daily functioning remain nonfigural until a benign or malignant regression occurs. In the regression the lived experiences of the past, which forged this structure, also become figural.

In order for the regression to remain benign as lived experiences become figural, the patient's ego and self integration must both be maintained. Integration allows for the continued operation of the secondary processes and the more highly developed primary process functions necessary in mediating the primary process experiences. In a benign regression the patient's integration is supported by the therapist through the attachment, allowing for the coordinated activity of the two processes to be maintained even when the lived experiences are extremely distressing and potentially disorganizing.

In a benign regression it is assumed that the more developed primary process functions serve to integrate the reworked and newer positively lived experiences into the self structure. At the same time, while operating in the background, the secondary processes serve to mediate and subsequently evaluate these lived experiences. Thus the secondary processes maintain reality testing, judgment, and impulse control so that the primary process lived experiences do not lead to distortions or acting out.

Drawing on Noy's (1969) formulation, both the reworked and new primary process subjective and affective experiences resulting from a benign regression lead to the development of more flexible and adaptive schemata in the self-structure. For Noy (1969), "This function always remains the main task of the primary processes--to assimilate and integrate new experiences into the gradually growing self" (p. 175).

With change and growth in the therapy it is assumed that the patient's primary process functions also develop in parallel with their secondary process functions. This assumption is supported in the results by therapists' statements indicating that the patient's growth was accompanied by more adaptive uses of primary process.

Regarding the process of a benign regression, the results indicated that some patients are able to regress and then return to secondary process functioning by the end of the session. For other, often more structurally impaired patients, the regression may continue outside of the session, requiring close management by the therapist. With either type of patient it appears that in the process of moving into a benign regression a part of their functioning remains constantly regressed between sessions. Here, part or all of the self structure appears to remain more figural and accessible and therefore more directly available for reworking. This conceptualization is consistent with the position that a benign regression is a process and steady state rather than a series of controlled shifts into and out of primary process. For example, one of the therapists in the study states:

> I also see it [benign regression], particularly in terms of one's emotional level of functioning, as a steady state.... I think that when you are really into benign regression, that

> steady state gradually goes down. It stays at that level between interviews. The idea that someone comes in, and you regress them, then they leave and they sort of pop back up to the surface is not the way it works. They go down there and they stay there. And then, from session to session you have a monitoring process, while the regression is continuing. And I see it as an emotional regression through time. They gradually go to more and more primitive experience.

The results indicate that the patient's constant state of benign regression can lead to their responding to others in the present in a less defended and often more child-like manner without the usual secondary process defenses obscuring what is going on. Quite literally any defensive facade, which previously masked deficits in the self structure and their effects on the patient's functioning, is less effective during a benign regression. Here the regression makes the immature and infantile parts of the self structure figural.

The relationship between the primary and secondary processes appears to be different in a malignant regression relative to a benign regression. In a malignant regression there is a breakdown in the coordinated activities of the primary and secondary processes. The secondary processes are unavailable or unable to maintain their usual functions, even within the background. These functions appear to operate at less adaptive levels and are unable to adequately meet the needs of contemporary reality. It is assumed that individuals prone to malignant regressions also have inadequately developed primary process functions which operate at an immature and more disorganized level. Thus more of their lived experiences tend to be primitive.

It appears that in a malignant regression the immature and infantile parts of the self structure become figural but are not

mitigated by secondary process functions. Consequently there is a critical loss of distance and reality testing in relation to the now figural primary process lived experiences, which lead to distortions of the relationship with the therapist. Here the therapist is experienced by the patient as if they were a previous object who was once the source of their distress, fears, and rage. Thus the lived experiences are no longer reworked but are acted out by the patient.

The patient's extreme distortions of the therapist in a malignant regression were identified as psychotic transference by the therapists in the results. It is assumed that a specific failure in attunement by the therapist recapitulates an essential failure by a past significant object. The result is that the lived experiences with that object become figural in relation to the therapist. Basically, there is a fit between the therapist's actions and some aspect of the patient's self structure which evokes a malevolent lived experience.

When the patient enters a state of terror, with a sense of impending annihilation, issues of detachment and disintegration generally dominate that lived experience. When these experiences are highly primitive and global the patient's ego can be overwhelmed resulting in the spread of the disintegrative experience to other areas of functioning. Here it appears that the patient's self and ego integration are both more globally impaired, with internal and external boundaries either weakened or dissolved. At this point the patient's externalization onto the therapist can reflect both a primary process distortion and a desperate maneuver to maintain integration through an external focus.

While the secondary processes are inadequate to the task of containing these lived experiences in a malignant regression, it is assumed that they continue to operate at some level. Although the patient's functioning can become quite pathological, it usually does not collapse into complete psychotic disorganization.

The results indicated that when a patient enters a malignant regression therapists wittingly or unwittingly employed various techniques directed at reestablishing the patient's secondary process functions, particularly their reality testing. Thus, there is an attempt to move the patient out of an exclusively self-centered and idiosyncratic position, dominated by primary process experiences, into an external reality-oriented position. When the patient is moved out of a malignant regression, and the therapy continues, the regression can become therapeutic if it is reworked.

While this theoretical model is incomplete and inadequate in fully explaining the operation of primary and secondary process functions in a regression, it can nevertheless be used as a starting point in understanding the process. For example, chronically regressed patients, such as schizophrenics, appear to have undergone a chronic loss of secondary process functions relative to their primary process functions. For these patients, the necessary balance and interaction between secondary and primary process has been lost. It can also be assumed that their primary process functions have remained primitive, having failed to development adequately. This formulation partially accounts for the rather primitive and disorganized primary process lived experiences which schizophrenic patients can openly manifest.

The projective identification form of malignant regression cited in the Results section represents a unique variation on this process. In this case the patient maintains their secondary process functions while introducing their primary process lived experiences into the therapist's experience. From an optimistic perspective, this type of malignant regression offers an opportunity to maximize the reworking potential since there is the possibility for both the therapist and the patient to maintain secondary process operations in order to deal with the primary process experiences. Of course this process is sequential, requiring that the therapist initially maintain integration and the attachment in containing and reworking the primary process experiences before the patient is able to do the same thing. If the therapist is unable to contain the primary process experiences the resulting distortions place the therapeutic process in jeopardy.

Another more subtle form of malignant regression also reported in the Results section involved an inappropriate fusion and merger by the patient at the beginning of the therapy prior to any real relationship being formed. This type of relationship was considered malignant because the patient's experience of the therapist was not mitigated by secondary process functioning and reality.

The merger relationship reflects a primary process distortion, much like the distortions in the standard malignant regression, based on the lived experiences with previous objects. However, here the idealized side of the split is projected onto the therapist in a manner which is not consistent with reality, reflecting a failure in the patient's secondary process functioning. Again, the problem is that

primary process functioning has been split off from secondary process functioning, where the patient cannot utilize the latter adaptively.

Several of the therapists in the research equated regression with transference. Indeed, it appears that transference is another term for the patient's lived experiences which they bring to every relationship. Therefore, in analysis the development of the transference neurosis accesses the negative primary process lived experiences of the patient.

Clinically, the model presented here indicates the need to work directly with both the ego and the self structures by utilizing both primary and secondary process functions. Thus, it accords equal importance to the two functions.

The Relationship Between the Past and the Present

The literature has generally portrayed regression as a movement away from the present towards the past. Freud's (1900/1965) temporal regression reflects a regression in time, where the psychic apparatus returns to a more primitive or earlier psychical state and level of functioning. The concept of a temporal shift by a patient in a regression is not supported by the results of this research, however.

The results indicate that regression is not a "going back" or "returning to the past" type of phenomenon. The earlier experiences and modes of behavior emerging in a regression have always been actively present in affecting the patient's functioning, but not figural. Since the lived experiences of the past are retained in the unconscious as primary process experiences the illusion is created of a temporal shift to the past when they become figural. The notion of

past and present is relevant only in terms of indicating how the past is carried forward and always represented in the present.

The patient's regression does not represent a shift between temporal dimensions, but rather, a shift between functions which reflect different modes of experiencing, assimilating, and dealing with the world. This shift occurs naturally in everyday functioning when previously unavailable primary process experiences emerge in response to some interactive matrix of psychic and environmental circumstances. The most obvious example of this shift occurs regularly within the sleeping state where dreams or nightmares confront us with primary process lived experiences which have been evoked in some manner by the experiences of the day. The dream is a concrete example of the regressive process in which past and present coexist.

The uncanny deja vu experiences may also reflect this temporary shift in processes. It is also possible to conceptualize humor or laughter as a rapid shift into and out of primary process functioning. If this conceptualization of humor is valid, then the controlled immersion in primary process experience may be one reason why humor is sometimes helpful in "loosening up" rigid patients like obsessives who attempt to stay secondary process bound.

Based on the present results and Noy's (1969) formulation, the so-called process of reworking the past in the present also appears to be a misrepresentation of what is actually occurring. The reworking involves those always present and active primary process lived experiences organized into schemata within the self structure. When the therapist recapitulates the failures of previous objects the

patient's response will run the same course it has always taken. Here less adaptive modes of functioning, which had their origin in the past, are employed in the present since no new forms of response have become available to the patient. In this sense past and present intersect.

Regression as a Natural Mechanism for Adaptation and Change

Given its pervasive role in human functioning, regression appears to represent an innate mechanism for improving the adaptive functioning and survival potential of humans. In addition to the potential for reworking and changing existing structures in therapy, regressions in everyday functioning allow for greater access to existing functions and experiences which can directly improve overt functioning. The result is greater mastery within interpersonal and environmental situations. An example was cited in the Results section where a patient gained access to nonverbal cues outside of the therapy which indicated the degree of security she experienced with other people. Her new sensitivity allowed for more appropriate relational choices through the use of both primary and secondary process functions and experiences.

The constructive and adaptive potentials of regression have generally been referred to as "regression in the service of the ego" in the literature (Hartmann, 1964; Kris, 1975). This term has usually been applied to improvements in creative functioning resulting from a controlled access to primary process experiences. The enhancement in functioning referred to in the example above, however, goes beyond improved creative talents and appears to reflect a more pervasive and fundamental mechanism which accesses visceral or intuitive information.

Therefore, this process may be more appropriately identified as "regression in the service of adaptation."

It appears that many of us in contemporary society have lost touch with the primary process elements of our experience. Contributing to this loss is the erroneous belief that reason and logic are higher order functions and therefore are more important functions to develop. Various forces, including movements away from a spiritually oriented to a more technologically oriented society, have tended to make us more secondary process bound.

In addition to the societal forces there appears to be an inherent fear in many of us around relinquishing our hold on secondary process. This fear is a more powerful force against accepting regression. In therapy this fear is sometimes operative within both the patient and the therapist, resulting in a covert alliance against any regressive tendencies. Various factors contribute to each individual's avoidance of regression but they appear to fundamentally come down to unconscious fears over the potential for detachment and disintegration.

Despite the various factors which run counter to the clinical use of regression, regressive therapy appears to be an effective and necessary process for therapeutic change based on the results and the literature. In order for the patient to regress, however, the therapist must accept and value for themselves the capacity to regress and entertain primary process experiences. As the results and literature indicate, the therapist's regression also allows them to directly "feel" what is occurring within the patient, the relationship, and themselves and to then make clinical use of this experience.

Through a benign regression the reworking process appears to foster healthier integration in all spheres of functioning so that a steady state, which is not volatile and vulnerable to disintegration, can be achieved. As the capacity to maintain integration improves there appears to be a parallel increase in the capacity for "regression in the service of adaptation."

In general, the benign regression appears to provide a mechanism for the individual to return to a more malleable and porous state similar to the playful flexibility and adaptability seen in children. Within this state there appears to be a increased potential for changes in self and ego structures in psychotherapy.

Regression has been inappropriately described as the opposite of progression, which, in turn, is generally defined as a forward movement and solidification of structures (Chaplin, 1975). It seems more appropriate to describe regression as a natural and necessary complement to progression since it allows for a loosening of the established structures so that they can be modified. Thus, regression and progression are intimately intertwined as complementary mechanisms for development. In order to regress there must be an initial progression. However, in order to continue to progress there must be regression.

Anna Freud (1963) believed that the process of shifting between progression and regression was a normal operation in children, which allowed for the working and reworking of developmental levels, tasks, and issues. Thus, it seems valid to assume that regression is a basic function we are all endowed with. The operation of healthy regression

is evident in the child's ability to readily shift between secondary and primary processes with no apparent threat to their functioning or structural integrity.

This operational fluidity seems to be a function of the natural flexibility and permeability of a child's self and ego structures. In most cases the self and ego structures, and particularly the defensive structures, are not rigidly entrenched in a child. Thus past and present experiences reside together in a more fluid interaction, reflecting the optimal state for learning and growth. The reduced capacity for flexibility and learning in adults appears to result, in part, from the defensive rigidity of their structures which are aimed at avoiding disintegration. This defensive rigidity results in an inhibition in the process of easily shifting between primary and secondary process functions.

Implications for Therapy

The implications for therapy have been identified throughout the Discussion. In summary, it appears that therapists should employ benign regression when it is appropriate in order to maximize the process of structural change. However, even with patients who are not appropriate for such an approach there needs to be a keen awareness by the therapist of the reworking potential contained within each "micro" regression and brief lived experience which patients continually present. Thus, the therapist needs to constantly attend to the patient's primary and secondary processes, dealing directly with the former in addition to analyzing the products of the regression.

The Methodology, Method, and Results

In this research the experiences of eight therapists were analyzed in order to obtain a more integrated and lucid understanding of the patient's regression in therapy. In the process, the results provided second hand information on the experiences of regressed patients based on the experiences of therapists. Obviously another approach to the phenomenon would have been to directly access and analyze the experiences of patients who had regressed.

In the initial stages of developing the research consideration was given to interviewing patients about their experiences with regression. After some evaluation and consultation this approach seemed unfeasible for several reasons. A central consideration was the anticipated difficulty in identifying and then enlisting patients for such a project. Issues involving where and how to recruit such a population, confidentiality, and the potential effects on patients still in treatment made it an unfeasible approach at the time. Therefore, the idea of interviewing patients was dropped.

Subsequently, the use of therapists as subjects was considered, but with some reluctance. This hesitation reflected the researcher's naivety about a therapist's capacity to understand, empathize with, and experience their patients' experiences in a regression. Interviewing therapists initially seemed like an outsider's view of regression which was, in part, a result of having been a patient in regressive therapy with little experience in being a therapist.

This ambivalence changed dramatically, however, in the process of becoming intimate with the experiences of eight therapists and in acquiring more clinical experience. In addition to experiencing what their patients experience, therapists can simultaneously maintain an overview and perspective which provides a broader and deeper understanding of the phenomenon. Indeed, there is a long tradition, beginning with Karl Jaspers, in which therapists have used clinical experience in order to understand and represent the phenomenological experiences of their patients (Varghese, 1988).

The results have validated for the researcher the value of using therapists to explore a phenomenon as difficult to examine as regression. As experienced clinicians, the therapists did not enter the research as detached reporters of a phenomenon. Having accumulated a good deal of experiential and theoretical knowledge they came to the research with their own preconceived beliefs about regression. This processing of clinical experience was in fact what the research was attempting to tap.

The Literature Review illustrated that the therapist's theoretical orientation can influence how regression is conceptualized. Thus different theoretical orientations could produce different results which were not necessarily representative of the phenomenon itself. In an attempt to evaluate such a possibility in this research, each therapist's theoretical orientation was obtained through the subject questionnaire and then gauged through the questions in the interviews. Consistent with the literature, this assessment indicated that the therapists either subscribed to a psychoanalytic orientation or to a

psychodynamic and object relations orientation. Despite the theoretical differences, however, the assessment did not indicate that theory dominated or dictated the therapists' experiences of regression. The results reflect a considerable degree of convergence in experiences despite theoretical differences between therapists. The commonality of experience was most likely the result of the extensive experience of these therapists which involved an average of 20 years of clinical work with regressed patients. It may be assumed that as experience increases there is a decreased reliance on theory.

In reference to methodology, the categories developed in the first two steps of the analysis and reduction process reflect the researcher's use of the phenomenological approach to formally look at specific questions. This procedure differs from the conventional approach only in the sense that the questions were made explicit rather than left to remain implicit but still operative. Realistically, it does not seem possible to separate the researcher's preconceived beliefs and questions from the process of the research even when an attempt is made to bracket them. The researcher's personal experiences and beliefs appear to always enter into and direct the analysis in some manner. Indeed Husserl acknowledged the impossibility of understanding a phenomenon independent of any existing structures since there is a universal tendency to give meaning to experiences (Varghese, 1988). Thus, phenomenological research should serve as a means of observing a phenomenon in its most natural form while acknowledging and addressing specific areas of inquiry relevant to the researcher.

Within this research the question can be raised as to whether or not the formalization of the questions and the resulting initial structure of the categories has violated the experience of the subjects. In the final analysis the subjects always provide the answer to the question of whether or not the researcher has remained faithful to their experiences. This question was in fact asked and answered by the subjects of this research. Thus, the methodology has remained close to each therapist's experiences while taking an approach which initially focuses on specific aspects of their experience.

Within the analysis and reduction process the researcher attempted to preserve and present as much of the original data as possible, without initially attempting to pare it down to micro structures. To reduce the data in this way would have violated the complexity of the therapists' experiences and lead to a loss of the heart of the data. Therefore, the analysis and reduction was used to organize and categorize the data into meaningful albeit large units. The subsequent development of the basic ground structures was presented within the Results section so that both a molar and a molecular view of the phenomenon could be maintained. As indicated in the Results section this approach has been used by other phenomenological researchers (Ashworth, 1985; Hannush, 1985; Mook, 1985; Polyzoi, 1985).

Directions for Future Research

While this research has shed light on regression as both a process and a phenomenon in therapy, more research is needed to validate and expand these results. Other researchers should attempt to replicate

the phenomenological analysis used in this research. In addition, a complementary analysis is needed which draws on patients as subjects. Perhaps an initial means of bridging the gap between patient and therapist, as well as dealing with the pragmatic difficulties in enlisting patients as subjects, would be to interview therapists about their own experiences of regression as patients.

In order to obtain patients as subjects it may be necessary to access a hospitalized population. While this population would generally yield data primarily on malignant regression it is nevertheless useful. Indeed, if regression is a unitary phenomenon then an evaluation of either type of regression will shed light on the entire phenomenon. Thus, interviews with chronically regressed patients could also prove to be useful.

In addition to the use of verbal interviews other approaches in dealing with specific aspects of the phenomenon should be considered. For example, the creative use of psychological testing instruments such as the Rorschach may be productive in exploring the relationship between primary and secondary process functions. Indeed, the Rorschach seems to evoke a brief regression and shift into primary process for many subjects during the free association.

Another avenue of exploration could involve other phenomena which appear to involve regression. Such research could include work with hypnotized subjects who appear to experience a shift in consciousness analogous to the shift reported in this research. Another approach would be to explore peoples' experiences of dreams and nightmares which are assumed to represent analogues to benign and malignant regressions.

In terms of specific questions which need to be addressed, the issue of whether a benign regression involves a return to a state of infantile dependency needs to be evaluated. Indeed, are dependency issues actually operative in this process? Attention should also be focused on describing and understanding the operations and structures involved in the shifts between primary and secondary process. The nature of primary process as it operates in everyday functioning also needs to be understood. These questions speak to the need for a better understanding of the structural elements in which both primary and secondary process are embedded. This line of inquiry necessitates reexamining the whole area of psychic organization since one cannot talk about regression without some conceptualization of psychic structures and functions.

There are many questions which remain unanswered and others which have been evoked by this research. Hopefully these questions will find answers in future studies. If this research has achieved nothing else, however, it has at least demonstrated that an elusive and seemingly unapproachable psychological phenomenon such as regression is accessible to formal research.

BIBLIOGRAPHY

BIBLIOGRAPHY

Alexander, F. (1956). Two forms of regression and their therapeutic implications. Psychoanalytic Quarterly, 25, 178-196.

Arnold, L. E., Selinger, S. S., & Koizumi, H. (1981). Limbic regression with derepression of oedipal feelings. The American Journal of Psychoanalysis, 41(1), 81-84.

Ashworth, P. D. (1985). Phenomenologically-based empirical studies of social attitude. Journal of Phenomenological Psychology, 16(1), 69-93.

Bailey, K. D. (1978). Methods of social research. New York: The Free Press.

Balint, M. (1960). The regressed patient and his analyst. Psychiatry, 23, 231-243.

Balint, M. (1968). The basic fault. New York: Brunner/Mazel.

Barrell, J. (1985). A comparison of phenomenological and experimental research methods. Unpublished manuscript, University of Tennessee, Knoxville.

Barton, H. R., & Kovan, R. A. (1978). Infantile ego states and adult clinical practice. The American Journal of Psychoanalysis, 38(3), 235-242.

Barton, H. R., & Kovan, R. A. (1979). Childhood ego states and adult clinical practice. The American Journal of Psychoanalysis, 39(2), 137-145.

Bienefeld, D. (1985). The two-way street: Aspects of regression in psychotherapy with aging patients. American Journal of Psychotherapy, 39(1), 86-94.

Boyer, L. B. (1983). The regressed patient. New York: Jason Aronson.

Brende, J. O., & McCann, I. L. (1984). Regressive experiences in Vietnam veterans: Their relationship to war, post-traumatic symptoms and recovery. Journal of Contemporary Psychotherapy, 14(1), 57-75.

Breuer, J. & Freud S. (1955). Studies on hysteria (J. Strachey, Trans.). New York: Basic Books. (Original work published 1893)

Brown, J. A. C. (1961). Freud and the post-freudians. Middlesex, England: Penguin Books.

Buddenhagan, K. (1984). The worlds of cancer patients. Unpublished doctoral dissertation. University of Tennessee, Knoxville.

Chaplin, J. P. (1976). Dictionary of Psychology. New York: Dell.

Cohn, F. S. (1957). Time and the ego. Psychoanalytic Quarterly, 26, 168-189.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), Existential-phenomenological alternatives for psychology (pp. 48-71). New York: Oxford University Press.

De Koning, A. J. (1982). Phenomenology. In A. J. J. De Koning, & F. A. Jenner (Eds.), Phenomenology and psychiatry (pp. 1-10). New York: Grune & Stratton.

Deutsch, H. (1985). A case that throws light on the mechanism of regression in schizophrenia. Psychoanalytic Review, 72(1), 1-8.

Eigen, M. (1979). Common failings in analysis and therapy. Psychotherapy: Theory, Research and Practice, 16(3), 246-251.

Eisendrath, S. J. (1984). Psychological concepts in the care of intensive care unit patients. International Journal of Psychosomatics, 31(3), 8-14.

Eissler, K. R. (1953). The effect of the structure of the ego on psychoanalytic technique. Journal of the American Psychoanalytic Association, 1, 104-143.

Esterson, A. (1970). The leaves of spring. London: Tavistock Publications.

Fairbairn, W. R. D. (1952). A revised psychopathology of the psychoses and psychoneuroses. Psychoanalytic studies of the personality (pp. 28-58). Boston: Routledge & Kegan Paul. (Original work published 1941)

Fairbairn, W. R. D. (1952). Endopsychic structure considered in terms of object-relationships. Psychoanalytic studies of the personality (pp. 82-136). Boston: Routledge & Kegan Paul. (Original work published 1944)

Fairbairn, W. R. D. (1952). Object-relations and dynamic structure. Psychoanalytic studies of the personality (pp. 137-151). Boston: Routledge & Kegan Paul. (Original work published 1946)

Fairbairn, W. R. D. (1952). A synopsis of the development of the author's views regarding the structure of the personality. Psychoanalytic studies of the personality (pp. 162-182). Boston: Routledge & Kegan Paul. (Original work published 1951)

Ferenczi, S. (1930). The principle of relaxation and neocartharsis. International Journal of Psychoanalysis, 11, 428-443.

Ferenczi, S. (1931). Child-analysis in the analysis of adults. International Journal of Psychoanalysis, 12, 468-482.

Ferenczi, S. (1949). Notes and fragments [1930-32]. International Journal of Psychoanalysis, 30, 231-242.

Fischer, W. F. (1982). An empirical-phenomenological approach to the psychology of anxiety. In A. J. J. De Koning, & F. A. Jenner (Eds.), Phenomenology and psychiatry (pp. 63-84). New York: Grune & Stratton.

Fleiss, J. L. (1981). Statistical methods for rates and proportions (2nd ed.). New York: John Wiley & Sons.

Freud, S. (1953). A general introduction to psychoanalysis (J. Riviere, Trans.). New York: Pocket Books. (Original work published 1920)

Freud, S. (1957). On the history of the psychoanalytic movement. In J. Strachey (Ed. and Trans.), The standard edition of the complete psychological works of Sigmund Freud (Vol. 14, pp. 1-66). London: The Hogarth Press. (Original work published 1914)

Freud, A. (1963). Regression as a principle in mental development. Bulletin of the Menninger Clinic, 27, 126-139.

Freud, S. (1963). Observations on "wild psychoanalysis. In P. Rieff (Ed.), Sigmund Freud: Therapy and technique (pp. 89-96). New York: Macmillan. (Original work published 1910)

Freud, S. (1963). The dynamics of the transference. In P. Rieff (Ed.), Sigmund Freud: Therapy and technique (pp. 105-116). New York: Macmillan. (Original work published 1912a)

Freud, S. (1963). Recommendations for physicians on the psychoanalytic method of treatment. In P. Rieff (Ed.), Sigmund Freud: Therapy and technique (pp. 117-126). New York: Macmillan. (Original work published 1912b)

Freud, S. (1963). Further recommendations in the technique of psychoanalysis: On beginning the treatment. The question of the first communication. The dynamics of the cure. In P. Rieff (Ed.), Sigmund Freud: Therapy and technique (pp. 135-156). New York: Macmillan. (Original work published 1913)

Freud, S. (1963). Further recommendations in the technique of psychoanalysis: Recollections, repetition and working through. In P. Rieff (Ed.), Sigmund Freud: Therapy and technique (pp. 157-166). New York: Macmillan. (Original work published 1914)

Freud, S. (1963). Further recommendations in the technique of psychoanalysis: Observations on transference-love. In P. Rieff (Ed.), Sigmund Freud: Therapy and technique (pp. 167-180). New York: Macmillan. (Original work published 1915)

Freud, S. (1965). The interpretation of dreams (J. Strachey, Trans.). New York: Avon Books. (Original work published 1900)

Frijling-Schreuder, E. C. M. (1966). The adaptive use of regression. International Journal of Psycho-analysis, 47, 364-369.

Friedman, S., Dunn, M. E., & Fishbein, C. (1986). Severe regressive reactions in sex therapy. Journal of Sex & Marital Therapy, 12(1), 65-72.

Gay, P. (1982). Liberalism and regression. Psychoanalytic Study of the Child, 37, 523-545.

Gill, M. M., & Brenman, M. (1959). Hypnosis and related states. New York: International Universities Press.

Giovacchini, P. L. (1984). Character disorders and adaptive mechanisms. New York: Jason Aronson.

Greenberg, J. R., & Mitchell, S. A. (1983). Object relations in psychoanalytic theory. Cambridge, MA: Harvard University Press.

Guntrip, H. (1969). Schizoid phenomena, object relations and the self. New York: International Universities Press.

Guntrip, H. (1971). Psychoanalytic theory, therapy, and the self. New York: Basic Books.

Guntrip, H. (1975). My experience of analysis with Fairbairn and Winnicott. International Review of Psycho-Analysis, 2, 145-156.

Hannush, M. J. (1985). The methodology of phenomenological psychobiography: The case of Richard Wright's Black Boy revisited. Journal of Phenomenological Psychology, 16(1), 39-68.

Hartmann, H. (1964). Essays in ego psychology. New York: International Universities Press.

Hoffman, I. Z. (1983). The patient as interpreter of the analyst's experience. Contemporary Psychoanalysis, 3, 389-422.

Isaac, S., & Michael, W. B. (1977). Handbook in research and evaluation. San Diego: Edits.

Jaffe, D. S. (1986). Empathy, counteridentification, countertransference: A review, with some personal perspectives on the "analytic instrument." Psychoanalytic Quarterly, 55(2), 215-243.

Joseph, E. D. (Ed.). (1965). Regressive ego phenomena in psychoanalysis. Monograph: The Kris Study Group of the New York Psychoanalytic Institute, 1, 68-103.

Kastner, M., & Neumann, M. (1986). A model combining two psychotherapeutic approaches in group psychotherapy. Psychotherapy, 23(4), 593-597.

Khan, M. M. (1975). Introduction. In D. W. Winnicott, Through paediatrics to psycho-analysis. New York: Basic Books.

Kris, E. (1956). On some vicissitudes of insight in psycho-analysis. International Journal of Psychoanalysis, 37, 445-455.

Kris, E. (1975). Selected papers of Ernst Kris. London: Yale University Press.

Kvale, S. (1984). Interpretation of the qualitative research interview. Tidskrift for Nordisk Forening for Pedagogisk Forskning, 4, 55-66.

Lindon, J. A. (1967). On regression: A workshop. Psychoanalytic Forum, 2(4), 293-316.

Little, M. Review of the selected papers of Sandor Ferenczi, M.D. vol. III. Final contributions to the problems and methods of psycho-analysis, edited by M. Balint. International Journal of Psychoanalysis, 38, 121-123.

Margulies, A. (1984). Toward empathy: The uses of wonder. American Journal of Psychiatry, 141(9), 1025-1033.

Meissner, W. W. (1981). Internalization in psychoanalysis. New York: International Universities Press.

Menninger, K. A., & Holzman, P. S. (1973). Theory of psychoanalytic technique (2nd ed.). New York: Basic Books.

Mook, B. (1985). Phenomenology, system theory and family therapy. Journal of Phenomenological Psychology, 16(1), 1-11.

Noy, P. (1969). A revision of the psychoanalytic theory of the primary process. International Journal of Psycho-Analysis, 50, 155-178.

Peebles, M. J. (1983). Handling psychiatric urgency. Bulletin of the Menninger Clinic, 47(5), 453-471.

Poland, W. S. (1986). The analyst's words. Psychoanalytic Quarterly, 55(2), 244-272.

Polyzoi, E. (1985). Reflective phenomenology: An alternative approach to the study of the immigrant experience. Journal of Phenomenological Psychology, 16(2), 47-72.

Psychological Abstracts Subject Index IV (Vol. 75). Arlington, VA: American Psychological Association.

Rinsley, D. B. (1982). Borderline and other self disorders. New York: Jason Aronson.

Richards, A. D. (1985). Isakower-like experience on the couch: A contribution to the psychoanalytic understanding of regressive ego phenomena. Psychoanalytic Quarterly, 54(3), 415-434.

Sellitz, C., Wrightsman, L. S., & Cook, S. W. (1976). Research methods in social relations (3rd ed.). New York: Holt, Rinehart and Winston.

Shershow, J. C., & Savodnik, I. (1976). Regression in the service of residency education. Archives of General Psychiatry, 33(10), 1266-1270.

Shields, J. D., & Choras, P. T. (1982). Treatment of the hospitalized adolescent: Management of regression during discharge. Adolescent Psychiatry, 10, 407-424.

Silver, A. S. (1986). Aspects of abrupt termination: Thoughts on losing my most chronic patient. Journal of the American Academy of Psychoanalysis, 14(1), 27-45.

Smith, A. H. (1981). Object relations theory and family systems: Toward a reconceptualization of the hypnotic relationship. Psychotherapy: Theory, Research and Practice, 18(1), 54-67.

Swanson, D. W. (1985). The purchase of regression. Perspectives in Biology and Medicine, 28(2), 243-250.

Varghese, F. T. (1988). The Phenomenology of Psychotherapy. American Journal of Psychotherapy, 42(3), 389-403.

Viederman, H. F. (1974). Adaptive and maladaptive regression in hemodialysis. Psychiatry, 37(1), 68-77.

Weiner, M. F. (1985). Regression in group therapy: A negative view. International Journal of Group Psychotherapy, 35(2), 209-224.

Winnicott, D. W. (1965). The theory of parent-infant relationship. In The maturational processes and the facilitating environment (pp. 37-55). New York: International Universities Press. (Original work published 1960a)

Winnicott, D. W. (1965). Ego distortion in terms of true and false self. In The maturational processes and the facilitating environment (pp. 140-152). New York: International Universities Press. (Original work published 1960b)

Winnicott, D. W. (1965). Ego integration in child development. In The maturational processes and the facilitating environment (pp. 56-63). New York: International Universities Press. (Original work published 1962a)

Winnicott, D. W. (1965). The aims of psycho-analytic treatment. In The maturational processes and the facilitating environment (pp. 166-170). New York: International Universities Press. (Original work published 1962b)

Winnicott, D. W. (1965). From dependence towards independence in the development of the individual. In The maturational processes and the facilitating environment (pp. 83-92). New York: International Universities Press. (Original work published 1963a)

Winnicott, D. W. (1965). Psychiatric disorder in terms of infantile maturational processes. In The maturational processes and the facilitating environment (pp. 230-241). New York: International Universities Press. (Original work published 1963b)

Winnicott, D. W. (1975). Primitive emotional development. In Through paediatrics to psycho-analysis (pp. 145-156). New York: Basic Books. (Original work published 1945)

Winnicott, D. W. (1975). Withdrawal and regression. In Through paediatrics to psycho-analysis (pp. 255-261). New York: Basic Books. (Original work published 1954a)

Winnicott, D. W. (1975). Metapsychological and clinical aspects to regression within the psycho-analytic set-up. In Through paediatrics to psycho-analysis (pp. 278-294). New York: Basic Books. (Original work published 1954b)

Winnicott, D. W. (1975). Clinical varieties of transference. In Through paediatrics to psycho-analysis (pp. 295-299). New York: Basic Books. (Original work published 1955)

Winnicott, D. W. (1975). Primary maternal preoccupation. In Through paediatrics to psycho-analysis (pp. 300-305). New York: Basic Books. (Original work published 1956)

APPENDICES

APPENDIX A

SUBJECT QUESTIONNAIRE

Interviewee Questionnaire

Interviewee No: ( )

(Please do not identify yourself on this form.)

1. Your clinical training/degree (i.e Clinical Psychology, Ph.D./Psy.D.; Psychiatry, M.D.; etc.):

_____

2. Years doing therapy since obtaining degree: _____

3. Years working with patients who have regressed in treatment:

_____

4. Your theoretical/clinical orientation (i.e. Psychoanalytic; Object Relations; Ego Analytic; etc.:

_____

APPENDIX B

INTERVIEW QUESTIONS

General Question I (Descriptions):

In your clinical work with patients in individual outpatient therapy, have you encountered the two types of regression, often referred to in the literature as therapeutic, benign, or controlled regression and pathological, malignant, or uncontrolled regression respectively?

If so, drawing on your clinical experience, describe the two forms of regression and address how they differ or might be similar. In doing this, can you present a detailed description of what a regressed patient presents with each form of regression within the therapy session (i.e. mental status, changes in ego functions, response to therapist, response to treatment process, content which emerges etc.)?

Can you present a brief descriptive case example, from your own clinical experience, of each type of regression? In each example, present the course of the patient's regression, both within and across therapy sessions. This should include an identification of any significant events or factors which you believe contributed in some way to the regression emerging.

Follow-up Questions - for Further Exploration or Clarification:

1. How do you know when the patient is regressing? What specific indicators do you use (i.e. changes in ego functioning, general functioning, content etc.)?
2. Is there a difference, in what is presented, between a patient who enters into a regression in the course of the therapy and a patient who comes into the therapy already functioning at a regressed level? If so, how do they differ?
3. Are there indicators of the level and type of regression which may be emerging in a patient, and what might they be. How would the two forms of regression, therapeutic and pathological, differ from each other and from an unregressed state, in terms of the patient's mental status?
4. How, and in what ways, is the therapeutic relationship affected by the two types of regression? Are the resulting therapeutic interactions significantly different and, if so, how? What is the nature of the therapeutic relationship with a regressed patient?
5. Are there often encountered regressive phenomena which regressed patients report or demonstrate? If so, describe them (i.e. somatic distortions, affective changes, time and space distortions, and interpersonal and relational changes etc.). Are there also indicative changes in thought content (i.e. more primitive and primary process content etc.) and though processes (i.e. less critical etc.)? If so, describe these changes.

6. Are there notable changes in either transference or countertransference phenomena which emerge with each form of regression? If so, what are the changes and are they different for each form of regression?

7. Are there distinguishable levels or progressive stages of a therapeutic and pathological regression and if so, what are they, and are they encountered in any form of sequence by the patient?

8. What is the process of a therapeutic regression (i.e. is it steadily unfolding and controlled or variable and unpredictable etc.) both within and across patients?

9. In a therapeutic regression, do the patient's recollections of childhood experiences etc. increase and if so, what forms can they take (i.e. reliving them, actively observing them, detached recall, reexperiencing the affective components only etc.)? Give examples.

10. What is the patient's response to either form of regression and how do they attempt to deal with the regression? Do you help the patient to understand the process of a therapeutic regression? Do you help them to understand what is happening when they enter a pathological regression? If so, how (i.e. what metaphors etc.)?

General Question II (Determinants):

Are there different predisposing factors (i.e. level of ego functioning and object relations development etc.) or situational precipitants (i.e. transactions in the therapeutic relationship) at work in the patient, the therapist, or the treatment process which result in the emergence of a therapeutic versus a pathological regression, and what might they be. Simply stated, what causes one versus the other to emerge in the treatment and is it always possible to discern the impetus for the patient's regression, be it therapeutic or pathological?

Follow-up Questions:

1. Does the patient go into or come out of a regressive state in response to or subsequent to specific events, interactions, or experiences in the therapy? Do these experiences differ for a therapeutic versus a pathological regression? If so, what are some examples? What are the predisposing factors which should also be considered?

2. Do you attempt to control or facilitate the patient's regression in any way and if so, how (i.e. reality focus, the use of a couch, silence, etc.)? What are the various factors which you take into consideration in encouraging versus restricting the regression of different patients and why?

3. Are all patients potential candidates for a therapeutic regression? Why or why not? With what types of patients would you attempt to facilitate a therapeutic regression? Are there criteria involving the patient's ego and character structure and object relations development which must be met before encouraging a therapeutic regression? If so, what are they?

4. What therapeutic elements or structures need to be in place before a patient will allow or enter into a therapeutic regression? How much resistance, if any, is encountered to the therapeutic regression and if this is variable over the course of the therapy, are there any critical points where the resistance is most evident?

5. Is your clinical technique and approach to dealing with a patient who is in a therapeutic regression different from a "non-regressed" patient? If so, how and why? How do you communicate and interact with a regressed patient, and is it different from how you deal with an "unregressed" patient?

6. How much variability is there between patients in their respective experiences of a therapeutic regression? Are there individual differences in character and ego structure which determine the degree of variability? What other factors contribute to the variability between patients?

7. Are there any parameters to how long a patient will maintain a therapeutic regression in the treatment? If so, how do you determine when to bring the regression to an end?

8. Can a therapeutic regression become pathological. If so how and why? What factors determine this?

9. What are all the factors which result in a patient entering into a pathological regression (i.e. is it a combination of deficits in ego functioning and object relations and specific events within the treatment and the therapeutic relationship)? How do you deal with a patient while they are in such a regression? What do you do to bring a patient out of a pathological regression?

10. Are all patient's potentially at risk to enter a pathological regression? If so, why and under what circumstances?

General Question III: (Explanations)

Do you have any working assumptions or hypotheses about what regression is as a general phenomena? (i.e. is it a movement "back" to earlier levels of functioning and experiencing as a result of the content that emerges in the therapy; is it a reactivation of previous earlier experiences and states which have lain "dormant"; or, is it an emergence of always present and active primitive processes which were "hidden" by various defenses and the "mask" of more mature functioning etc.)?

Is regression a unitary phenomena which can take different forms, or are the two forms of regression two fundamentally different phenomena under the rubric of regression?

Do you have any hypotheses about the nature of the two forms of regression. That is to say, what is a therapeutic regression and what is a pathological regression? Are there any other forms of regression which are significant to the treatment process?

Follow-up Questions

1. What is regression (i.e. is regression a partial reactivation of earlier ego states and experiences in the therapy so that there is a

reexperiencing of affective, cognitive, and physical states associated with very early experiences etc.)? Is is appropriate to use a unitary description and explanation of regression or is the phenomena quite different depending on whether one is addressing a therapeutic or a pathological regression?

2. What makes a therapeutic regression therapeutic? What is the expected outcome of a therapeutic regression? Basically, why do you encourage and use a therapeutic regression in treatment?

3. What makes a pathological regression pathological? What is the outcome of a pathological regression for the treatment process and the therapeutic relationship?

4. In either a deep therapeutic regression or a severe pathological regression is there a developmental level or ego state which the patient's behavior reflects or manifests (i.e. does a therapeutic regression reflect a level of primary dependency, does a pathological regression reflect a chaotic, primitive, and infantile ego state etc.)? Do you associate a therapeutic regression with ego integration and a pathological regression with ego disintegration? Is it appropriate to use these concepts with regression?

5. Is therapeutic regression, in some form, a part of every treatment process even if it is not overtly acknowledged? If so, how? Can significant characterological or structural change, as opposed to changes in the defensive structure, occur without the patient entering into an extended and deep therapeutic regression?

6. In conceptualizing and explaining regression, do you draw from any specific theoretical orientation and if so, what theory (i.e. psychoanalytic, object relations etc.)? Has the theory been sufficient to adequately explain what you have encountered in your clinical work with regressed patients? What other sources have you drawn from in arriving at your current formulation of regression (i.e. other theories, other clinicians, clinical experience etc.)?

APPENDIX C

LETTER OF INTRODUCTION TO POTENTIAL PARTICIPANTS

Dear (Potential Research Participant):

I am a graduate student in Clinical Psychology, at the University of Tennessee, and currently in the process of collecting data for my doctoral dissertation. I am writing to request your participation in this research as an interviewee. The title of the doctoral research project is Therapeutic and pathological regression: A clinical description of the phenomena and an analysis of precipitating factors within the treatment process. The data for the research will be drawn from interviews with clinicians, like yourself, who have worked with patients who have regressed during the course of a long-term individual outpatient therapy. I am approaching you as a potential interviewee and contributor because of your unique clinical knowledge of, and experience with, what has been an historically ambiguous and often misunderstood phenomenon, clinical regression.

Historically, the literature on regression has characterized it as either the bane of the treatment process or as the essential element for genuine relational and characterological change. It is the goal of this research to empirically examine the phenomena in terms of how it presents itself within the treatment process to therapists. The perceptions, experiences, and insights of a number of therapists will be integrated to provide a detailed description and comparative analysis of the two types of regressive phenomena which can be encountered within a long-term treatment process. These will be referred to as therapeutic and pathological regression within the research, and parallel Michael Balint's benign and malignant regression respectively. The research will also attempt to explore the possible factors contributing to the emergence of one form of regression versus the other within the therapy. A phenomenological methodology will be used to analyze the interviews in order to maintain the integrity of the phenomena and to retain the richness and depth of the data provided by clinicians.

If you choose to participate in the research, your involvement would require about 2 1/2 hours of time split unequally between two different tasks performed several weeks apart. Initially, you will be asked to do a 1 1/2 hour audio taped interview with me. That will conclude your initial involvement in the research. I will subsequently transcribe your interview into a written transcript and reduce it to basic meaningful units for later analysis. Your follow-up involvement, which will occur several weeks after the interview and require about 1 hour of your time, will involve your reviewing the reduced transcript. This will provide a mechanism to verify that it has remained faithful to what you presented in the interview. Written feedback from you will be requested on this, and any additional feedback or information will

also be welcome. The written feedback on the reduced transcript will conclude your active involvement in the research.

The interview will follow a semi-structured format in which my role will be to set the topics of the interview through the use of general questions, and to follow up these general questions with more specific questions in order to clarify and expand upon what you have presented. In order to expedite entrance into the topic, all the general and potential follow-up questions will be given to you prior to the interview. Please be assured that none of the questions will risk any potential breaches in patient confidentiality.

The interviews will be kept fully confidential with all audio tapes and transcripts coded numerically and only identifiable through a master list. Only I will have access to the audio tapes and the master list which will be locked in a secure file cabinet in the office where I work. After the research has been completed, the audio tapes will be erased and the master list will be destroyed in order to maintain full confidentiality.

Personally, I am excited about the topic and the research. It is the kind of research which values the clinician's unique skills and knowledge and attempts to draw deeply from this resource as a valid source of data. I hope that you also find the research of interest and would therefore choose to participate in it. As a participant, you will be given a copy of the dissertation so that you can share in the results.

In order to expedite your response to this request, I will call you by phone within the next two weeks regarding your involvement. I hope you do not find this procedure to be presumptuous or intrusive on my part. I will be able to answer any questions you have about the research or the nature of your participation when I contact you by phone. If you agree to participate I will arrange a time and place for the interview which is most convenient for you and sensitive to your time requirements and constraints.

Thank you for giving this request your attention. If you would like to contact me by phone, I am currently living and working in Connecticut, having done my Clinical Internship here. My phone number and address, as well as my Committee Chairman's, follow.

Sincerely,

Arnie Trasente
1117 Waterbury Rd. #2A
Cheshire, CT 06410
H: (203) 272-1519
W: (203) 242-4431 X2760
Dr. Leonard Handler, Ph.D.
Professor
310C Austin Peay Building
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APPENDIX D

INFORMATION AND CONSENT FORM

Arnold D. Trasente
(Home)
(203)272-1519
1117 Waterbury Rd., #2A
Cheshire, CT 06410
(Work)
(203)242-4431 X2760
Mount Sinai Hospital
Department of Child & Adolescent Psychiatry
500 Blue Hills Avenue
Hartford, CT 06112

I am a graduate student in Clinical Psychology, at the University of Tennessee at Knoxville, and currently in the process of collecting data for my doctoral dissertation. The data for the doctoral research will be drawn from interviews with therapists, like yourself, who have worked with patients who have regressed during the course of their therapy. This pertains to patients in an outpatient individual therapy. Given your clinical experience with this population of patients, I am asking for your consent at this time to participate in this research.

The doctoral research will attempt to focus, and give definition to an historically ambiguous and often misunderstood phenomena, regression. It will look at both sides of regression, the therapeutic and the pathological, in order to provide a more lucid description and a better understanding of both phenomena. As a therapist who has used regression as a clinical tool and who has dealt with patients in a pathological regression, you have a unique wealth of clinical experience and knowledge about this elusive and ambiguous phenomenon. I would like to draw upon your unique knowledge, as well as the knowledge of other therapists like yourself, in order to obtain an integrated overview and in depth understanding of regression within the treatment process. As indicated earlier, the research will attempt to do this through the use of semi-structured interviews focusing on various aspects of both therapeutic and pathological regression.

If you choose to participate in this research, your involvement would require about 2 1/2 hours of time split unequally between two different tasks performed several weeks apart. Initially, you will be asked to do a 1 1/2 hour audio taped interview with me. That will conclude your initial involvement in the research. I will subsequently transcribe your interview into a written transcript and reduce it to basic meaningful units for later analysis. Your follow-up involvement, which will occur several weeks after the interview and require about 1 hour of your time, will involve your reviewing the reduced transcript. This will provide a mechanism to verify that it has remained faithful

to what you presented in the interview. Written feedback from you will be requested on this, and any additional feedback or information will also be welcome. The written feedback on the reduced transcript will conclude your involvement in the research.

As a subject in the research, the foreseeable risks to you should be minimal. In the interview, there will be no requests for any patient names or any potentially revealing material about a specific patient. Thus no breaches in patient confidentiality should be encountered. In addition, there will be no requests for information about yourself which could be potentially self-damaging in any way. Never-the-less, the interviews will be kept fully confidential with all audio tapes and transcripts coded numerically and only identifiable through a master list. Only the researcher will have access to the audio tape of your interview and the master list, both of which will be locked in a file cabinet in a locked office where the researcher works. After the completion of the dissertation research, the audio tape will be fully erased and the master list will be destroyed in order to maintain full confidentiality.

If you agree to participate in this research, please understand that you are free to withdraw you participation at any time without questions, and that any interview data you have provided will be destroyed immediately. At the conclusion of the research you may obtain a copy of your interview transcript, should you wish to have it. A copy of the dissertation will also be provided so that you can share in the results of the research. Since the topic is quite interesting to me, I hope you will share this interest and maintain your participation in the study.

There are at least two potential benefits to you as a subject in the research. First, the interview process may serve to focus and integrate your thinking on regression, offering an opportunity to better understand what you have observed and experienced directly. Secondly, the results of the research, which will integrate your clinical experiences with those of other therapists, could prove useful in further expanding your understanding of the phenomena and subsequently add to your clinical expertise. In more general terms, the research should serve to formalize regressive phenomena for other therapists, by providing a more meaningful and clearer definition and description. This could potentially lead to a better understanding and means of dealing with these phenomena, as they emerge in the therapy, leading to better treatment outcomes.

If you have any questions at this time, or at any time prior, during, or after your participation in the research, please feel free to approach me. You will be given a copy of the information and consent form for your own records. The form will contain my address and telephone number should you wish to contact me at any time about the research, and please feel free to do so.

I have read the above information and consent form, and agree to participate in this research project.

Signature:_____ Date:_____

APPENDIX E

EXAMPLE: RESULTS OF SECOND ANALYSIS AND REDUCTION PROCEDURE

Benign Regression - Descriptions

Interviewer: When a patient starts to go into a benign regression, what do you see? What are the indicators that the patient's starting to go into that form of regression?

Therapist: Whether its after a year or four years the main thing I notice is, before that happens, the transference is not hot, either negative or positive. Its like its in place. Its like you move to become a part of the environment. So usually, when you have that feeling that you're not being closely watched all the time, being closely inspected, that that's an indicator that this can happen at that time. The other thing is, that the person begins to talk and explore things in a way as if you're not there. Its like you're assumed you're there. So that you become part of their environment at that time, a comfortable part of their environment. And also in that situation, there is a difference in their eyes, you have a feeling like their eyes are focused in such a way that they're thinking about something internally.

And [when the object relationship with the therapist is secure], then [the patient] can roam internally in their fantasies and explore what's going on and what they see and what they think about things. There can be a reduction in critical thinking, and a reduction in secondary thought process, but the main thing you see different than the first case [of a malignant regression] is you don't see fear. The person is playing around with ideas, musing with ideas that often aren't critically correct. Its like primary process without the fear. And when that's going on, I see the heart of therapy, because the person's playing around with something they've always been afraid of, but they feel there's a safe circumstance to play around with it. The main thing you see is the absence of hypervigilance, the absence of agitation, the absence of the figural paranoid fix on the therapist. And also, the person can be very comfortably recalled from that kind of regression without feeling like they're being injured or anything. Its more like doing something together.

Interviewer: With benign regression, what are the effects on the therapeutic relationship?

Therapist: Its very positive, in connection with the relationship, and its an indicator that things are going in a good stable way with the relationship.

Interviewer: With a benign regression, do your patients report certain kinds of experiences, i.e. time distortions, perceptual distortions, etc.?

Therapist: Yea, often the main thing I notice is, that in a positive regression, patient's as they come out of it towards the end of the session, will indicate their surprise at how rapidly the time of

the session passed. So, in that positive state, there seems to be a speed up of time. And other times, in a playful way, they will talk about perceptual distortions. They'll talk about colors and shapes in such a way that it has a very fluid quality to it. They'll go through various perceptual changes about things, and as they do it they don't seem particularly alarmed about it. They're sort of playing with the changes in perceptions.

Interviewer: Could you give an example of a benign regression?

Therapist: This is a patient who I'd seen for a number of years. And, after about two and a half years of treatment, this was three times a week treatment, the person was on the couch. And, after being on the couch for about a year, the person would take off in fantasies, where they would take off in fantasies about me and about the world. But the fantasies about me were in terms of a very powerful paternal figure, like a father who was very kind and holding the person. So, as the person would explore the internal world and the fantasies and what have you, the image the person had would be that I would be holding the person. And, either the person would be held like an infant, or an older child sitting on my lap and telling stories about what was going on. The feeling I had to it, the way the patient described it, was that it felt very much like that to that person. It was like that was really happening. The person was actually like a little kid sitting on my lap talking about events or things that happened or just resting. And that's often a quality that would happen in this case, where the person would peacefully be quiet, not in an agitated resistant silence, but be quiet and feel very supported during the quiet period. And sometimes, the person would come in and be quiet most of the session or often announce, either at the beginning or end of that, "I just need to rest." But felt very able to rest in the situation.

As the person was doing this with me, in the world this person was demonstrating ever increasing ego functions. Becoming more masterful, using better judgement, developing more positive relationships, doing work in her profession, maintaining friendships. Also eliminating some negative relationships. So, even though there was regression going on, the main quality that was happening in the world was an increase in ego functions.

Interviewer: So the regression was contained within the therapy?

Therapist: Yes.

Interviewer: Did it spill out in any way into the outside world?

Therapist: Yea, the main way it would spill in the outside, or maybe being made use of on the outside, is the person could make use of much more subtle primitive cues about the nature of a relationship. So they make use of all those internal cues to evaluate the nature of the relationship with people in the outside world.

Interviewer: You're describing an affective attunement.

Therapist: Right.

Interviewer: Would there be other kinds of spilling of the regression, in terms of the level of functioning, outside the session?

Therapist: Yea, when this was going on, and this was even with the positive regression, a lot of times there would be day to day things that people would forget, they wouldn't pay attention to. And

sometimes, in situations where they would usually be more focused on what was going on, they would find themselves floating, they're not fully there, they just went off somewhere.

Interviewer: What do you see in terms of changes, if any, in the transference and countertransference, or your own affective experience?

Therapist: With the benign regression, the main thing that happens is a general feeling of letting down of defenses, and even a letting down of secondary thought processes. There's a more relaxed atmosphere, and a capacity more to play with associations in my mind. To feel more positive, more relaxed about the person. And probably, a much greater willingness to share some of my thoughts with the patient. So, the way to put it in that state of affairs, I feel much more comfortably together with the person, and much more relaxed about the relationship. And probably, I'm functioning much more at a primitive level in the relationship back and forth with the patient. Much more playing around with more primary process ideas.

Benign Regression - Determinants

Therapist: I don't think its necessary to find out what exactly was the impetus for the regression, either to manage it or make use of it therapeutically. Sometimes you find out, sometimes you don't. The biggest factor for a benign regression that I've found is that in someone's developmental history, if they had some significant experience with a positive object relationship, that would be the biggest factor for the allowance of something to take place in the therapy that's good, a good regression. Often its a relationship we don't find out about until long into therapy. It's a relationship that might have been forgotten about by the patient. But generally, I find that if something did in fact happen that was positive, that they can have an anchor point or a memory that something good can take place between people. If its in there somewhere, and often there can be very negative relationships all around it. But, if it never happened to a significant degree with the person, then to have a benign regression take place is almost impossible.

Interviewer: What does that particular positive relationship provide the patient with, structurally or any other way?

Therapist: The main thing it provides the patient with is the idea of hope with respect to the issue of object constancy. Which, in turn, would provide hope with the finding of a resting place where they could develop ego functions. That's probably, in theoretical terms using a Guntripian expression, his idea of a regressed libidinal ego where there is a seeking a wanting of a positive object relationship. Something that might have been put in cold storage for a long time, but its still there somewhere. And something happened somewhere with the primary attachment figure that was positive. Well it might have had all sorts of things stacked on top of it, but its still there somewhere, it can be called on.

Now the main characteristic that I always talk about with a benign regression is that the object relationship [with the therapist] is in place and that the regression never gets ahead of the power of the

relationship. Its like the object relationship is so in place, the person can forget about it. Its funny because when I think about it the object relationship is very strong but nonfigural at that point. So its just assumed that its there, its in place, it can be called on at any time to anchor reality or tie things down. And of course, this kind of benign regression, just by the very nature of the way I describe it, happens later in therapy. For that kind of regression to happen, lets say within the first year of therapy, I think of as unrealistic. Because there isn't that strong enough bond for it to take place. So its like you're there, the person does not have to worry about you, and you become a given in the situation. And, on the basis of that, then they can roam internally in their fantasies and explore what's going on and what they see and what they think about things. And also, the person can be very comfortably recalled from that kind of regression without feeling like they're being injured or anything. Just get more reality oriented before the session winds down. And, its much more of a cooperative arrangement. And the patient, whether they verbalize it or not, understands the wisdom of returning from the regression before returning to the world.

Interviewer: You describe what sounds like a patient who feels held.

Therapist: Right, the person felt very connected with me, very held. And, its like the relationship with me, in the person's mind, was very much in place. The feeling I had, to be technical for a moment, was that object constancy was in place and then it was being made use of.

Interviewer: Are there any factors within the therapy session and the relationship with the therapist that facilitate a benign regression?

Therapist: The benign regression, when it starts to happen, it seems very important at that point to recognize it and then, in a positive way, to keep myself out of the way. In other words, not to get into any pseudoactivity to try to prevent it or not to introduce my ideas about it, but just to allow it to emerge. And, if I check the situation and see that the usual things I look for in a negative regression aren't there, then what I generally do is pull myself back, pay attention, but stay out of the way. It's like I become the guardian of the event, but I'm not actively trying to do something to the event. So, when I can do that, it seems like that's the most important thing within the therapy that allows it to happen.

Interviewer: With benign regression, do you ever become active in trying to facilitate its arrival? And if you do, what do you do?

Therapist: When I think its time, the thing that I do that would help bring that about is, and I guess its a form of activity, I bring about less structure in the situation. For example, the idea of someone being on the couch is a therapeutic move that I might introduce to promote a modulated, positive regression. At some point, when I think the person's ready I might suggest that they do that. Generally, I would get quieter and introduce less structure into the situation. I notice when I do those things, that generally that will promote the regression and allow it to come out.

Benign Regression - Explanations

Interviewer: You identified the process of the regression going on in the session and integrative changes going on outside of the session. How does the regression affect the improved functioning? What is the process?

Therapist: The main process that happens is, the person through the regression in the therapy session, first allows themselves to become aware of more information that's going on inside them. Probably one of the biggest things that happens in the positive regression, is people are allowed to notice more about themselves and other people, and will talk about that. The first place where it happens is in the therapy situation itself, where they begin to notice what they're doing or what's going on. And perceptually, and by way of evaluation, I think they take that same process into the world and they notice what's going on in more detail. And I think the main reason is, to put it in kind of simplistic terms, there's just more information available to evaluate situations. And the way it happens is, more rigid defenses, as they begin to get through that through the therapeutic regression, find that some of the rigidity of the defensive structure is not necessary now in their life. And, as they begin to let that drop away and find out that nothing catastrophic happens then that allows an influx of information to become available to them. And then, they make use of that in the external world to make judgements, make decisions, and choose relationships.

Interviewer: So it facilitates a process because you really don't identify any content as a part of this. Is content secondary?

Therapist: Yea, content is very secondary to the overall process the person goes through. It's like ways of seeing things, and perceiving things, and evaluating themselves, and ways they feel about themselves. So between cognitive and affective processes of ways of functioning in both territories, it seems like the main thing that differs, regardless of what in particular they're talking about.

Interviewer: Theoretically, you haven't really used this term but, regression to dependency, do you use that in conceptualizing regression?

Therapist: Yea, there's a lot of dependency and dependency gratification that takes place in benign regression. Where there's a lot of dependency needs being met. And I see that as very much an integral part of it. Now I clearly differentiate between a dependent relationship and an addictive relationship. And the main difference is, with a dependent and dependency gratification relationship, that it leads to a strengthening of the object relationship. And the proof of the pudding is that you see a growth in ego functions in the patient. And, in an addictive relationship, the person becomes fearful of the object relationship, and you do not see any significant growth in the person's capacity to function in an autonomous fashion. A lot of times, the stage is set for a very negative regression by getting into an addictive relationship. Where the person needs, desperately needs, but is very fearful of, and it does not facilitate growth outside of

the situation. That sets the stage for paranoia and a malignant regression.

The overall goal in a benign regression, and this is what you're shooting for, is those arrested ego functions begin to develop. And wherever they got arrested at, they begin to improve from that state of arrest. And this should happen across the board with ego functions. If there's something not developing across the line of various ego functions, I become suspicious that there's something going on in the relationship that's inhibiting or prohibiting that ego function from developing. But, the purpose is autonomy development. And, the underpinnings for all that to take place is to have all the ego functions beginning to develop again.

Malignant Regression - Descriptions

Therapist: With the malignant regression, usually I see that early in the treatment, emerging. The main characteristics you see are paranoid characteristics. Where somebody, lets say within the first six sessions, begins to regress in my presence. And probably, the main quality I'd see with that type of regression is the changes in the patient's eyes. You see a lot of hypervigilance. Sometimes you see a look in their eyes where they get unfocused, get a crazy look in their eye. And definitely a feeling that they're responding to a great deal of internal stimulation. Overall, what I see in that is a lot of fear, projection of very negative power onto me the therapist. Like I'm going to do something bad to them, or I'm trying to control them. And, the more intense this is, the more you do see the going away of ego functions. The person's judgement, even the person's perception begins to get very distorted in the situation. In extreme cases there is an actual physical perceptual distortion of me. Where they think I'm starting to look very menacing or I'm changing the way I'm looking in front of them. And the more that goes on, the more the patient gets very afraid. Another type of malignant regression, that once again happens early in treatment, but is not so destructive, is when someone fuses very rapidly. They come in and you have a feeling, there the signals are that there's a presuming of a very close connection between the two of us. Like our thinking is in common about this and that, we see things the same, we have common interests. It's like the way the phenomena of falling in love is described, like, from the patient's point of view, this is a perfect fit, and is making all sorts of assumptions. Now the main thing that's different than that and the first type of regression I described, was that in this type you don't see the fear. The person feels fairly comfortable with this kind of fusion, and it doesn't seem to cause that many difficulties. You can begin to alter that later, but it isn't such an emotionally intense situation as in the first case. Most of the malignant, destructive type of regression I see is the type I described first. Where the person is rapidly moved into a very paranoid posture about the situation and just takes off and feels, the total phenomenological response they have is "I'm in danger."

Interviewer: When that gets activated do you become a significant past object for the patient?

Therapist: Yea, the way patient's describe it, the way they describe me at that time, I think I actually become that object for the person. That I'm evil, and I'm trying to do bad things to them, I'm trying to control them. I describe that as a psychotic transference.

Interviewer: Short of a termination of the therapeutic relationship, are there any repercussions from a malignant regression on the relationship?

Therapist: Yea, I think it happens on both sides. I think it frightens the patient, and makes the therapist and the patient very wary about the relationship. It serves notice to me as a therapist this whole thing, no matter how its looking, can blow up in a minute. You can never presume there's a relationship there, and so you're always a little skittish about anything you get into. And when something starts to regress you always worry, are we going in the wrong direction here? It's like something happens and neither party ever forgets it because of the frightening, dangerous quality of it.

Interviewer: So it has an enduring effect on the relationship.

Therapist: Yea, right.

Interviewer: With a malignant regression, do the patients make complaints or reports of their experiences that recur across patients?

Therapist: Yea, in a malignant regression often the complaints are very negative, very bitter. In the direction of the therapist, I don't understand, I don't care, sometimes I'm making fun of them, I'm trying to humiliate them. Sometimes, if I call someone back from a malignant regression, they're very angry that I made them come back. But also, I noticed that simultaneous with the anger with me there's a relief. They seemed to be relieved that I noticed what was going on and I stopped it. So they're both, I think, angry but sort of calmed down when I stop that type of malignant regression.

Interviewer: Can you present a case example of a malignant regression?

Therapist: The malignant [regression] took place from session one to session six, and it started with the first session. Where a person came into my office, was very emotional, very tearful, disorganized, but started talking about a lot of emotional content at once. I noticed the person's eyes, it would change throughout the session, but the way the person's eyes would focus, it would seem at times very disconnected. The first two sessions were like that, they were very emotional. And the person would look at me in an accusatory fashion and say "look do you understand, are you listening to what I'm saying" that sort of thing. Around session four, the person became very angry with me and in the midst of this thing felt that I was trying to humiliate him, and upset him. We got through that, and I called the person back from the regression over and over again, and we got through that part but the person was very angry about me calling him back from the regression. He got very formal at one time, and recanted his grievances with me since the first session, and said that he wasn't going to regress like that. He realized he had to get things together, and he needed to talk about things, and get things fastened down.

After that point, after being recalled from the regression he continued throughout the therapy to be angry about it. But, from that point on, he started to get organized and started to structure things, but always held a grudge about that. And in that particular case, it never moved from that type of regression to a benign regression. Most of what happened in therapy was always structuring, keeping things together, keeping things organized. Trying to build up and strengthen ego functions rather than doing anything to promote regression.

Interviewer: Did you manage to get the patient out of the malignant regression, or was it a constant struggle against the malignant regression?

Therapist: After a while the patient was out of it. And, when I was talking about the person's negative affect towards me, even that was not regressed. It was much more of an organized paranoid reaction. But it didn't have regressive take off power after that.

Interviewer: What do you see in terms of changes, if any, in the transference and countertransference, or your own affective experience?

Therapist: Well, in the malignant regression it makes me feel wary, somewhat suspicious. Sometimes, what I refer to as, clinically paranoid about the situation. So, the way I feel about the situation, my countertransference would be making me more suspicious as a therapist and less trusting of the relationship.

Malignant Regression - Determinants

Therapist: With the malignant regression, usually I see that early in the treatment, emerging.

The main precipitant that I see of a negative [malignant] type of regression, the ones I've seen have almost always involved having a significant primary attachment figure who was actively destructive to the individual in an intrusive, invasive, in a very negative way, not just neglectful. And they did that in such a way, that it really damages ones sense of comfortable regressive, positive relatedness.

Interviewer: Are there any factors within the therapy session and the relationship with the therapist that are critical?

Therapist: Yea, for example, where I as a therapist get too active, my activity can trigger that kind of malignant regression. When I move too quickly, then in the situation what I think it does is, it triggers the idea of being controlled, being invaded, being intruded upon. And that would trigger the paranoia and the malignant regression in that situation. So the problem there as a therapist is, how do you structure to prevent regression without getting too intrusive for the person.

Interviewer: Would it be accurate to say that your activities, in some way, recapitulated the activities of the destructive significant figure?

Therapist: Right, what happens is I do something that's just like the positive regression. There's a fit with something that preexists or something I do that's a negative fit with something that preexists. And I either say it in a certain way or do something in a certain way that causes that negative primary object to get reactivated in the

person. And, whatever that might be, be it the way I do something, the way I don't do something, there's something ready there to trigger it.

Interviewer: When that gets activated do you in fact become that object for the patient?

Therapist: Yea, the way patient's describe it, the way they describe me at that time, I think I actually become that object for the person. That I'm evil, and I'm trying to do bad things to them, I'm trying to control them. And, with a very high frequency, the word humiliation is put in there. And, I can't help but feel that this is, they're really telling me about the experience they had with the primary object. You are that person. It isn't like you're like that person, I'm it, right here in the room with the person. So there is very little distance or perspective on it, I'm it at that time.

When that happens I describe that as a psychotic transference.

In that type of situation [where the patient feels they're in danger], I would intervene with reality and tell the patient, saying "I can see you're very afraid or concerned about something, you're starting to regress, I want you to stop the regression. I'm not going to hurt you." If it looks like the time is a factor that's causing the person problems I'll cut the interview short and set up another time. So I won't meet with them as long, but I might meet with them more frequently just to touch base to bring back the reality of the situation. And also, would move to get the person away from very abstract internal issues to very external mundane issues. But get very concrete, very near future content, and not let things float. And, in this situation I become more active than I would usually in a therapeutic situation. Trying to make the reality of me come through more so they can see what I'm really saying, who I really am, what I may be doing. Make me and everything else more real for them, more concrete for them to slow down that process. And then, that's usually a signal to me that in the early stage of the treatment a lot of what I'm going to be doing is preventing regression. I'm not going to be doing anything to encourage regression. If anything, the interviews will be more structured.

Sometimes, if I call someone back from a malignant regression, they're very angry that I made them come back. But also, I noticed that simultaneous with the anger with me there's a relief. They seemed to be relieved that I noticed what was going on and I stopped it. So they're both angry but calmed down when I stop that type of malignant regression.

Interviewer: With the malignant regression, what are the effects on the therapeutic relationship?

Therapist: Well the worst effect is that it can terminate the therapy if it gets severe enough. Therapy and myself as the therapist would be so frightening that the person would bolt, they would leave therapy. Its a very difficult situation because what happens is you have to get active to do something to stop the regression, but often your activity is interpreted as intrusive and hostile by the patient. And, when that idea gets fixed, when there's no relationship or enough of a relationship to reach the person, often the person will leave therapy. Now this happens most frequently within the first ten

sessions. Usually, the people get into a malignant regression later, but it's enough of a relationship to be called back and settle things down.

Interviewer: Can a benign regression become malignant? If so, how?

Therapist: Yea, the main way it can happen is, if either for the needs of the therapist, or the needs of the patient, you begin to forget about the necessity of always keeping the relatedness and the modulation ahead of the regression. If you forget about that, you can take a positive regression and it can outdistance its coverage and then become frightening. I think some of that happens in every regression. But, if it gets too far away from the coverage, then it can get into a form of a negative regression, and activate paranoia. So, no matter how positive the regression is or how kind of loose things get, there always has to be a part of the therapist, and a part of the patient too, attending to, "are we getting beyond our control mechanisms, are we getting beyond our object relatedness here?" And, if that happens, then it has to be called back, brought back so it stays lined up with the degree of comfort control. What happens is you begin to see the appearance of fear. As soon as you see that, its time to bring things back.

Interviewer: Your metaphor conveys a sense of a patient having lost you in some way.

Therapist: That's right, its almost like the developmental phases where early on the locomotion outdistances the ego coverage. And the kid knows how to walk, he can walk to the end of house and then turns around and says "where's mom?" They begin to take off and you go "oops where did you go, I can't find you?" So then you move them back and remind the person more actively that I'm here. Or sometimes, you might ask the person if they start to get away, to sit up for a while, help them refocus, know where they are, what's going on.

Interviewer: If the patient does lose you, do they become enraged because they feel you have not kept up your end of the bargain?

Therapist: Sometimes they become angry about it and afraid. The general emotional response though is like somebody getting lost. And rage isn't the typical response. There's fear, and then when there's a reconnection there's relief. And there can be some anger, some rage about it, but that seems secondary to the fear and relief.

Interviewer: Do you think all patients are capable of a malignant regression?

Therapist: Yea, everybody is capable of a malignant regression. And basically, what you have to do is, with anybody for any reason whatsoever, just bring about regression through unstructuring, and either loose or not have in place modulation or relatedness. And then, you have a malignant regression with anybody. Its just like you get them unstructured, you get them into primitive material, and you get them deserted. It's malignant.

Interviewer: Where there's an inappropriate fusion and merger, why do you see that as pathological regression.

Therapist: The only reason I see that as pathological, its not therapeutically that problematic, but the reason I see it as

pathological is because the person is willing to make a very strong connection on the basis of nonreality. That there's not an object relationship. It's strictly a projection, and they have no reality data yet to begin to fasten that to. The reason I see that as destructive is that if it goes on too far, then you're setting up problems later, down the road. If there's anything that deviates from that idealization, it could be very destructive to the therapy. It's like something that could break up the positive transference. So, if it looks like its going that way I might do a few things, not a whole bunch of things, to disrupt the person's image. I wouldn't want to disrupt all of it, but I just want to introduce the idea "I might be different from the image you have of me" if it starts floating away too far.

Malignant Regression - Explanations

[No content for this category]

Regression in General - Descriptions

[No content for this category]

Regression in General - Determinants

[No content for this category]

Regression in General - Explanations

Interviewer: Do you have any working assumptions or hypotheses about what regression is as a general phenomena? (i.e. is it a movement "back" to earlier levels of functioning and experiencing as a result of the content that emerges in the therapy; is it a reactivation of previous earlier experiences and states which have lain "dormant"; or, is it an emergence of always present and active primitive processes which were "hidden" by various defenses and the "mask" of more mature functioning etc.)?

Therapist: I don't see regression as a sequential thing. I Think the last category, the one of a phenomena that's always a capability, that's always present within the individual, and under certain circumstances it emerges. I don't feel like I'm going back to something way back then. I think it's something that's being carried by the person right now. And in keeping with that idea, I feel like what we call primary process and what we call secondary process are not in order. I don't think you have primary then you drop it and you start secondary. I think there is a line of development for primary process and a line of development for secondary process, and they both develop in their own way. If you have an overpredominance of either one you can have problems. So, it's not like something happened developmentally and stopped, I see these things there always. In certain situations one predominates over the other, but they're always there. When we talk about pathology, what happens is one or the other

of these becomes so frightening to the person, usually its primary process, that all sorts of things are done to stop it from emerging. So, I would see that capacity for regression, either benign or malignant, always sitting there for anybody to make use of in a positive or negative way at anytime in their life. Its just always there, and there's an attraction to it and a fear of it. I think people are attracted to regression, which is really no problem if you have connections and controls to go along with that attraction to it. But, if you don't have any of those controls, then what happens is people become very afraid of regression. But they don't stop being attracted to it. I think everybody's attracted to it.

Interviewer: Why, what is the attraction?

Therapist: The attraction goes in two ways. I think the attraction is to wanting to explore what is going on inside, and explore a more primitive level of functioning that we all carry with us at all time. In an evolutionary sense, it's like wanting to get back to where we came from. To get familiar with a more primitive level of functioning. Because, in a very basic sense, that does control who we are, and how we respond to situations, and what we do with most of our life. So in a way, if you know nothing of that, you don't know who you are in a very real sense. I think people do want to know who they are. Also back there, in a very primitive way, is where our early attachments are, probably prememory attachments, where they exist. And, I think a lot of times we have experiences we can reexperience that we can't remember. And, in the primary world that's probably where the most satisfying and the most terrifying relationships reside. So, since we're always looking for some form of object gratification, I would think back in that world it's trying to avoid evil relationships, but we never give up on the idea of trying to reconnect with the good ones.

Interviewer: In terms of theory, is there a developmental level, that you can identify a patient being in with either form of regression?

Therapist: The closest one that it comes to would be the developmental stage prior to individuation and separation, using Mahler. Because both the malignant and benign, the experience you get is that there is not a differentiation between me and the other person, and there's not firm boundary lines yet. And, that's what makes it so good when its good and so terrifying when its bad. It's like before any description of a developmental level, before there's a clear differentiation between self and object. And there's sort of a fluidity, a going back and forth. So if I had to locate it, I would say it was before a clear separation, individuation takes place.

Interviewer: And that would apply across both forms of regression?

Therapist: Yea, I would see that in both forms.

Interviewer: Because of the self-object fluidity primarily?

Therapist: Right.

Interviewer: In conceptualizing and explaining regression, do you draw from any specific theoretical orientation?

Therapist: The theoretical orientation I use to think about regression, more than any other theoretical orientation probably, is the object relations work of Michael Balint. Who makes a very clear differentiation between a positive transference and a therapeutic environmental matrix that facilitates a positive regression. And there, the reason that I think of him is, he clearly differentiates the difference between the idea of fusion, positive transference, and also the idea of a positive connectedness. And he emphasizes, more than most theoreticians, that things can be very primitive, but simultaneously very positive when the circumstances are set up correctly. Michael Balint emphasizes the idea, along with D. W. Winnicott, that dependency is a necessary prerequisite for development, but it has to be managed in a particular way, a modulated way for it to happen.

Interviewer: And has the theory been sufficient for you to draw on to deal with what you see clinically?

Therapist: Yea, just about all clinical situations I run into I can organize under that understanding of what's going on.

APPENDIX F

FEEDBACK PROCEDURE

Dear ,

As I "warned" you in the letter several weeks ago, enclosed are the materials you'll need to complete the second part of your involvement in my Dissertation Research. This is a feedback procedure which will allow me to assess the validity of the results of the phenomenological analysis that was used to systematically reduce and reorganize your interview. Basically, your feedback is necessary to assess whether the enclosed transcript has remained faithful to your clinical experience and understanding of regression. You can also use this procedure to convey any additional thoughts you may have had on regressive phenomena since our interview. The following information will take you through the feedback process.

1. Enclosed you'll find:
   (A) A transcript with your identification number [25].
   (B) The question outline used to structure our initial interview.
   (C) A 60 minute audio-tape cassette.
   (D) A stamped, addressed return envelope.

2. You can present your feedback in either written or verbal form and it can be as brief or involved as you wish. For example, you can simply write on the transcript that it is a valid representation of what you presented in the interview. Or, you can identify where the transcript is not an accurate representation and why. If you use the audio-tape cassette, it may be convenient to put number's on the transcript, by the sections you are addressing, and use the numbers to refer to these sections.

3. When you read the transcript, you will find that your interview has been reorganized into 9 content categories or cells which constitute a 3 by 3 matrix. One dimension of the matrix addresses the types of regression addressed which are (1) benign regression, (2) malignant regression, and (3) regression in general. The other dimension addresses the three areas of question which were focal in the interview. These were (1) descriptions, (2) determinants, and (3) explanations of each type of regressive phenomena. The question outline has been included in order to give you a sense of what I was addressing with each question area. The descriptions and explanations areas are relatively straight forward. The determinants section includes possible precipitants for each type of regression as well as the process that unfolds with each. For example, this would include statements on the process of a benign regression becoming malignant and the effects on the therapeutic relationship.

Please let me know if any specific statements are placed in the wrong categories i.e. that a statement in the determinants of benign regression section really belongs in the section on explanations of benign regression, etc. Please feel free to comment on how I have structured the material as well, and whether you believe it is useful and valid.

In this procedure, it was not my intention to quantify the interviews. That is, I was not interested in producing neat little units of meaning of a sentence or less. I have attempted to preserve the context and flow of your thoughts in the interview, and this has resulted in large chunks of data. You will find some redundancy in the transcript where the same content is found in more than one section. In some cases I felt that it was not meaningful to break up a paragraph which addressed several areas which were so intimately intertwined in your thinking. In other cases, statements may have applied equally to more than one section.

4. Your written or audio-taped comments on the transcript can be returned in the stamped, addressed envelope. If you have any questions please feel free to call me. In order to expedite this process I have set a deadline for receiving your feedback. **The deadline is September 8th**, about 3 weeks from when you receive this material. If you find that the transcript is valid, and needs no revision, you may choose to let the deadline pass as a communication of this. I will not make any further attempts to solicit your feedback by phone or mail. Therefore, no subsequent response from you will be taken as an acknowledgement of the validity of the transcript.

I would like to thank you again for your participation and involvement in the research. The data from all the interviews is already producing a fascinating picture of the phenomena. Which is to say, I'm still very excited about the research. When it is completed I will send you a copy of the dissertation which I hope you will also find interesting.

Sincerely,

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APPENDIX G

SCORING MANUAL

Introduction

Before getting into the steps of the analysis and reduction process, I would like to give you a sense of my orientation and direction in this research. Hopefully, this will serve to guide your process in following the analysis and reduction procedures which I have used.

The research attempts to bring into focus, and give definition, to an historically ambiguous and often misunderstood phenomena, regression in the therapeutic setting. As both a clinical and developmental phenomena, it is often defined as the opposite of progression, and cast in a pejorative light due to its malignant possibilities. This is unfortunate since it appears that regression also has a positive side, which can be a part of everyday functioning. It can also have a potentially positive role in therapy. Thus the research attempts to examine both sides of regression, the benign, therapeutic, or controlled forms, and the malignant, pathological, or out of control forms, which patients present in therapy. The general goal is to provide a more lucid description and better understanding of both phenomena.

In order to do this, the research draws its data from focused interviews with therapists who are familiar with both forms of regression. The interviews were usually about one and a half hours long, and were focused through the use of a list of "Interview Questions." These questions delineate three areas of inquiry which reflect natural focal points for examining regressive phenomena in a clinical setting. This allowed for an analysis of benign and malignant regression, as well as regressive phenomena in general, along three specific dimensions. These are identified in the list of Interview Questions (attached) as descriptions, determinants, and explanations, respectively. A reading of the Interview Questions should familiarize you with the types of questions and content which each area addresses. My focus then, in examining regression in the therapeutic process, was on exploring the descriptions, determinants (possible precipitating factors), and explanations, provided by therapists, for benign and malignant regression.

The Analysis and Reduction Process

The manual takes you through a series of steps which will allow you to follow the same procedures, which I used, in rendering the original transcript (identified as Interviewee # 23) into a meaningful clustering of thematic units. Since graphic materials are often more

useful that written directions, examples are provided for each step in the process.

Step One:

This step involves two components. The first is to read and reread the transcript. The goal is to become familiar with it in a manner that allows you to "get into" the therapist's experience, and assume their perspective and orientation towards the data.

The second component involves a relatively straight forward reduction of the transcript in four stages, which requires:

1) Summarizing statements where it is not necessary to retain the original language (i.e. some of the questions used by the interviewer).

2) Condensing longer statements, sections, elaborations, or descriptions by deleting irrelevant or redundant content, phrases, and words. Simply stated, this gets rid of the dead wood.

3) Removing other statements which repeated earlier statements.

4) Removing other statements which are not relevant or related to the study.

This step results in a reduced transcript which contains focused and condensed statements on regressive phenomena.

An example of the results of this step is presented in Example B. The original transcript is presented in Example A. The protocol you are working on should be in the format of Example B after completing this step.

Step Two:

This step involves a move away from the straight forward data reduction process into a more subjective area of analysis. It involves organizing the data into three broad thematic clusters or units. The clusters represent the types of regression being examined, benign and malignant regression, respectively, and a third cluster representing content that reflects general regressive phenomena or general statements about regression. The clusters are labeled: General Regression; Benign Regression; and Malignant Regression.

The content for General Regression reflects descriptions, determinants, explanations, and examples of regressive phenomena which cannot be identified as only benign or malignant. It includes general statements about the phenomena, statements inclusive of both types of regression, general explanations about the therapist's theoretical orientation, or general questions they have about the phenomena. Content indicative of a Benign Regression reflects descriptions, determinants, explanations, and examples of the positive, therapeutic aspects and forms of regression. Content indicative of a Malignant Regression reflects descriptions, determinants, explanations, and examples of the pathological aspects and forms of regression.

Thematic units in the protocol can generally be identified, based on shifts from one content or topic theme to another. This often follows the interviewer's questions. However, at times it may be

necessary to break apart paragraphs or statements which integrate two, or all three, of the thematic units.

An example of the results of this step is provided in Example C. The protocol you are working on should be in the format of Example C after completing this step.

Step Three:

This step is similar in function to the previous step, and involves another clustering of themes. These themes are based on the organizational structure of the Interview Question list, which focused on three general questions. Consequently, the thematic clusters in this step are identified as: Descriptions; Determinants; and Explanations.

The content which each theme represents can be best understood by examining the list of Interview Questions. The analysis at this point involves assigning and organizing the data into each of these themes. This is done within each of the three broad clusters already developed. The result is nine clusters of data reflecting a 3 X 3 matrix. Thus, there are descriptions, determinants, and explanations for benign regression, malignant regression, and general regression, respectively.

An example of the results of this step is provided in Example D. The protocol you are working on should be in the format of Example D after completing this step.

Step Four:

The last step combines the activities of the previous three steps in order to arrive at the most accurate and meaningful reduction of the data. This step contains three components.

The first component involves reading through the reduced protocol, which is now clustered into 9 thematic units, and checking that the right content has been assigned to the right cluster. Where this has not been the case, the data should be reassigned to the appropriate cluster. This insures that the thematic clusters contain the appropriate data.

The second component involves a return to the first step of reducing the protocol where any redundant or unnecessary statements, phrases, or words remain. This should trim the protocol down to the most salient content, while retaining the language of the therapist.

The last component involves a reorganization, where necessary, of the content within each thematic cluster. The intent here is to place similar content together in a manner that seems logical and meaningful.

The process which I used in this step is shown in Example D. This is reflected in the penciled in notes and redlining on the protocol. The numbers in the margins are my short hand for identify the various clusters (i.e. 23 represents explanations for benign regression). The results of this last step are provided in Example E. The protocol you finish with should be in the format of Example E.

VITA

Arnold Donald Trasente was born on July 22, 1948 in Newark, New Jersey, where he attended elementary schools through the fourth grade and was raised as an only child within a large extended family of Italian heritage. In 1958 his family, including his maternal grandmother, moved to Wayne, New Jersey where he completed his elementary and high school education, graduating from Wayne Valley High School in June 1967. In September 1967 he entered Syracuse University and received a Bachelor of Science degree in January 1972 in Advertising Copywriting, with a minor in Psychology.

After living in Boston, Massachusetts he attended Fairleigh Dickinson University in Madison, New Jersey, in 1978, as a part-time masters level student in Psychology. In September 1981 he entered the doctoral program in Clinical Psychology at the University of Tennessee, Knoxville. He completed his predoctoral internship at the Mount Sinai Hospital Child and Adolescent Psychiatric Service in Hartford, Connecticut and received the Doctor of Philosophy degree in 1990.

He now lives in Cheshire, Connecticut and is a member of the Connecticut Psychological Association and the Honor Society of Phi Kappa Phi. He is currently working as a therapist with children, adolescents, and adults in both inpatient and outpatient settings.