The International Journal of Psychoanalysis
(1955). International Journal of Psycho-Analysis, 36:16-26

Metapsychological and Clinical Aspects of Regression Within the Psycho-Analytical Set-Up[1]

D. W. Winnicott

SYNOPSIS

Attention is drawn to the subject of regression as it occurs in the psycho-analytic setting. Case reports of successful psychological treatments of adults and children show that techniques that allow of regression are increasingly being used. It is the psycho-analyst, familiar with the technique required in treatment of psycho-neurosis, who can best understand regression and the theoretical implication of the patient's expectations that belong to the need to regress.

Regression can be of any degree, localized and momentary, or total and involving a patient's whole life over a phase. The less severe regressions provide fruitful material for research.

Emerging from such study comes a fresh understanding of the 'true self' and 'false self', and of the 'observing ego', and of the ego-organization which enables regression to be a healing mechanism, one that remains potential unless there be provided a new and reliable environmental adaptation which can be used by the patient in correction of the original adaptive failure.

Here the therapeutic work in analysis links up with that done by child care, by friendship, by enjoyment of poetry, and cultural pursuits generally. But psycho-analysis can allow and use the hate and anger belonging to the original failure, important effects which are liable to destroy the value of therapeusis brought about by non-analytic methods.

On recovery from regression the patient, with the self now more fully surrendered to the ego, needs ordinary analysis as designed for the management of the depressive position and of the Oedipus complex in interpersonal relationships. For this reason, if for no other, the student should acquire proficiency in the analysis of the carefully-chosen non-psychotic before proceeding to the study of regression. Preliminary work can be done, however, by a study of the setting in classical psycho-analysis.

AIM

It is my aim in writing this paper to bring forward for discussion the matter of regression as it appears in the course of psycho-analysis.

The study of the place of regression in analytic work is one of the tasks Freud left us to carry out, and I think it is a subject for which this Society is ready. I am trying to put something into words, something which belongs to psycho-analysis to-day, and I base this idea on the fact that material relevant to the subject occurs frequently in papers read before the Society. Usually attention is not specifically drawn to this aspect of our work, or else it is referred to casually under the guise of the intuitive or 'art' aspect of psycho-analytic practice.

The subject of regression is one that has been forced on my attention by certain cases during the past dozen years of my clinical work. It is, of course, too vast for full presentation here and now. I shall choose therefore those aspects that seem to me to introduce the discussion in a fruitful way.

PRELIMINARY CONSIDERATIONS

Analysis is not only a technical exercise. It is something that we become able to do when we have reached a stage in acquiring a basic technique. What we become able to do enables us to co-operate with the patient in following the *process*, that which in each patient has its own pace and which follows its own course; all the important features of this process derive from the patient and not from ourselves as analysts.

Let us therefore clearly keep before our minds the difference between technique and the carrying through of a treatment. It is possible to carry through a treatment with limited technique,

---

(Received 26 March, 1954)

[1] Paper read before the British Psycho-Analytical Society on 17 March, 1954.

and it is possible with highly developed technique to fail to carry through a treatment.

Let us also bear in mind that by the legitimate method of careful choice of case we may and usually do avoid meeting aspects of human nature that must take us beyond our technical equipment.

CLASSIFICATION

Choice of case implies classification. For my present purpose I group cases according to the technical equipment they require of the analyst. I divide cases into the following three categories. *First* there are those patients who operate as whole persons and whose difficulties are in the realm of interpersonal relationships. The technique for the treatment of these patients belongs to psycho-analysis as it developed in the hands of Freud at the beginning of the century.

Then *secondly* there come the patients in whom the wholeness of the personality only just begins to be something that can be taken for granted; in fact one can say that analysis has to do with the first events that belong to and inherently and immediately follow not only the achievement of wholeness but also the coming together of love and hate and the dawning recognition of dependence. This is the analysis of the stage of concern, or of what has come to be known as the "depressive position". These patients require the analysis of mood. The technique for this work is not different from that needed by patients in the first category; nevertheless some new management problems do arise on account of the increased range of clinical material tackled. Important from our point of view here is the idea of the *survival of the analyst* as a dynamic factor.

In the *third* grouping I place all those patients whose analyses must deal with the early stages of emotional development before and up to the establishment of the personality as an entity, before the achievement of space-time unit status. The personal structure is not yet securely founded. In regard to this third grouping, the accent is more surely on management, and sometimes over long periods with these patients ordinary analytic work has to be in abeyance, management being the whole thing.

To recapitulate in terms of environment, one can say that in the first grouping we are dealing with patients who develop difficulties in the ordinary course of their home life, assuming a home life in the pre-latency period, and assuming satisfactory development at the earlier infantile stages. In the second category, the analysis of the depressive position, we are dealing with the mother-child relationship especially around the time that weaning becomes a meaningful term. The mother holds a situation in time. In the third category there comes primitive emotional development, that which needs the mother actually holding the infant.

CASE

Into the last of these three categories falls one of my patients who has perhaps taught me most about regression. On another occasion I may be able to give a full account of this treatment, but at present I must do little more than point out that I have had the experience of allowing a regression absolutely full sway, and of watching the result.

Briefly, I have had a patient (a woman now fifty) who had had an ordinary good analysis before coming to me but who obviously still needed help. This case had originally presented itself as one in the first category of my classification, but although the diagnosis of psychosis would never have been made by a psychiatrist, an analytical diagnosis needed to be made that took into account a very early development of a false self. The false self had played into the analysis of hysteria. For treatment to be effectual, there had to be a regression in search of the true self. Fortunately in this case I was able to manage the whole regression myself, that is to say, without the help of an institution. I decided at the start, six and a half years ago, that the regression must be allowed its head, and no attempt, except once near the beginning, was made to interfere with the regressive process which followed its own course. (The one occasion was an interpretation I made, arising out of the material, of oral erotism and sadism in the transference. This was correct but about six years too early and out of place because of the regression of the patient that I did not yet fully believe in. For my own sake I had to test the effect of one ordinary interpretation. When the time came for the interpretation it had become unnecessary). It was a matter of about three or four years before the depth of the regression was reached, following which there started up a progress in emotional development. There has been no new regression. there has been an absence of chaos, though chaos has always threatened.

I have therefore had a unique experience even for an analyst. I cannot help being different from what I was before this analysis started. Non-analysts would not know the tremendous amount that this kind of experience of *one* patient can teach, but amongst analysts I can expect it to be fully understood that this one experience that I have had has tested psycho-analysis in a special way, and has taught me a great deal.

The treatment and management of this case has

called on everything that I possess as a human being as a psycho-analyst, and as a pediatrician. I have had to make personal growth in the course of this treatment which was painful and which I would gladly have avoided. In particular I have had to learn to examine my own technique whenever difficulties arose, and it has always turned out in the dozen or so resistance phases that the cause was in a counter-transference phenomenon which necessitated further self-analysis in the analyst. It is not my aim in this paper to give a description of this case, since one must choose whether to be clinical or theoretical in one's approach, and I have chosen to be theoretical. Nevertheless I have this case all the time in mind.

The main thing is that in this case, as in many others that have led up to it in my practice, I have needed to re-examine my technique, even that adapted to the more usual case. Before I explain what I mean I must explain my use of the word regression.

DEFINITION OF REGRESSION

For me, the word regression simply means the reverse of progress. This progress itself is the evolution of the individual, psyche-soma, personality and mind with (eventually) character formation and socialization. Progress starts from a date certainly prior to birth. There is a biological drive behind progress. It is one of the tenets of psycho-analysis that health implies continuity in regard to this evolutionary progress of the psyche and that health is maturity of emotional development appropriate to the age of the individual, maturity that is to say in regard to this evolutionary process.

ORGANIZATION MAKING REGRESSION POSSIBLE

On closer examination one observes immediately *that there cannot be a simple reversal of progress*. For this progress to be reversed there has to be in the individual an organization which enables regression to occur.

We see:

a. A failure of adaptation on the part of the environment that results in the development of a false self.

b. A belief in the possibility of a correction of the original failure represented by a latent capacity for regression which implies a complex ego organization.

c. Specialized environmental provision, followed by actual regression.

d. New forward emotional development, with complications that will be described later.

Incidentally I think it is not useful to use the word regression whenever infantile behaviour appears in a case history. The word regression has derived a popular meaning which we need not adopt. When we speak of regression in psycho-analysis we imply the existence of an ego organization and a threat of chaos. There is a great deal for study here in the way in which the individual stores up memories and ideas and potentialities. It is as if there is an expectation that favourable conditions may arise justifying regression and offering a new chance for forward development, that which was rendered impossible or difficult initially by environmental failure.

It will be seen that I am considering the idea of regression within a highly organized ego-defence mechanism, one which involves the existence of a false self. In my patient this false self gradually became a 'caretaker self', and only after some years could the caretaker self become handed over to the analyst, and the self surrender to the ego.

One has to include in one's theory of the development of a human being the idea that it is normal and healthy for the individual to be able to defend the self against specific environmental failure by a *freezing of the failure situation*. Along with this goes an unconscious assumption (which can become a conscious hope) that opportunity will occur at a later date for a renewed experience in which the failure situation will be able to be unfrozen and re-experienced, with the individual in a regressed state, in an environment that is making adequate adaptation. The theory is here being put forward of regression as part of a healing process, in fact, a normal phenomenon that can properly be studied in the healthy person. In the very ill person there is but little hope of new opportunity. In the extreme case the therapist would need to go to the patient and actively present good mothering, an experience that could not have been expected by the patient.

There are several ways in which the healthy individual deals with specific early environmental failures; but there is one of them that I am calling here the freezing of the failure situation. There must be a relation between this and the concept of the fixation point.

REGRESSION TO FIXATION POINTS

In psycho-analytic theory we often state that in the course of instinct development in the pregenital phases *unfavourable* situations can create

fixation points in the emotional development of the individual. At a later stage, for instance at the stage of genital dominance, that is to say when the whole person is involved in interpersonal relationships (and when it is quite ordinarily Freudian to speak about the Oedipus complex and castration fears), anxiety may lead to a regression in terms of instinct quality to that operative at the fixation point, and the consequence is a reinforcement of the original failure situation. This theory has proved its value and is in daily use, and there is no need to abandon it while at the same time looking at it afresh.

> A simple example would be that of a boy whose infancy had been normal, who was given an enema, first by his mother, and then by a group of nurses who had to hold him down, at the time of tonsillectomy. He was then two. Following this he had bowel difficulty but at the age of nine (age at consultation) he appears clinically as a severe case of constipation. In the meantime there has been a serious interference with his emotional development in terms of genital fantasy. In this case there happens to be the complication that the boy has reacted to the giving of the enema as if it had been a revenge on the part of the mother on account of his homosexuality, and what went into repression was the homosexuality and along with it the anal erotic potential. In the analysis of this boy one knows that there would be acting out to be dealt with, a repetition compulsion associated with the original trauma. One knows also that the changes in this boy would not follow a simple re-enactment of the trauma but would follow ordinary Oedipus complex interpretation in the transference neurosis.

I give this as an ordinary case illustrating a symptom which was a regression to a fixation point where a trauma was clearly present.

REGRESSION TO GOOD EXPERIENCE PATTERNS

Analysts have found it necessary to postulate that more normally there are *good* pregenital situations to which the individual can return when in difficulties at a later stage. This is a health phenomenon. There has thus arisen the idea of two kinds of regression in respect of instinct development, the one being a going back to an early failure situation and the other to an early success situation.

I think that insufficient attention has been drawn to the difference between these two phenomena. In the case of the environmental failure situation what we see is evidence of *personal defences* organized by the individual and requiring analysis. In the case of the more normal early success situation what we see more obviously is the memory of *dependence*, and therefore we encounter an *environmental situation* rather than a personal defence organization. The personal organization is not so obvious because it has remained fluid, and less defensive. I should mention at this point that I am relying on an assumption which I have often made before and which is by no means always accepted, namely, that towards the theoretical beginning there is less and less of personal failure, eventually only failure of environmental adaptation.

We are concerned, therefore, not merely with regression to good and bad points in the instinct experiences of the individual, but also to good and bad points in the environmental adaptation to ego needs and id needs in the individual's history.

REGRESSION AS REVERSAL OF PROGRESS

We can think in terms of genital and pregenital stages of the development of *instinct* quality, we can use the word regression simply as a reversal of progress, a voyage back from genital to phallic, phallic to excretory, excretory to ingestive. But however much we develop our thinking in this direction we have to admit that a great deal of clinical material cannot be fitted into the framework of this theory.

The alternative is to put the accent on ego development and ego-dependence, and in this case when we speak of regression we immediately speak of environmental adaptation in its successes and failures. One of the points that I am trying to make especially clear is that our thinking on this subject has been confused by an attempt to trace back the ego without ourselves evolving as we go an increasing interest in environment. We can build theories of *instinct* development and agree to leave out the environment, but there is no possibility of doing this in regard to formulation of *early ego* development. We must always remember, I suggest, that the end result of our thinking about ego development is primary narcissism. In primary narcissism the environment is holding the individual, and *at the same time* the individual knows of no environment and is at one with it.

If I had time I would point out the way in which an organized regression is sometimes confused by clinicians with pathological withdrawal and defensive splittings of various kinds. These states are related to regression in the sense

that they are defensive organizations. The organization that makes regression useful has this quality distinct from the other defence organizations in that it carries with it the hope of a new opportunity for an unfreezing of the frozen situation and a chance for the environment, that is to say, the present-day environment, to make adequate though belated adaptation.

From this is derived the fact, if it be a fact, that it is from psychosis that a patient can make spontaneous recovery, whereas psycho-neurosis makes no spontaneous recovery and the psycho-analyst is truly needed. In other words, psychosis is closely related to health, in which innumerable environmental failure situations are frozen but are reached and unfrozen by the various healing phenomena of ordinary life, namely friendships, nursing during physical illness, poetry, etc., etc.

REGRESSION TO DEPENDENCE

It seems to me that it is only lately in the literature that *regression to dependence* has taken its rightful place in clinical descriptions. The reason for this must be that it is only recently that we have felt strong enough in our understanding of individual psyche-soma and mental development to be able to allow ourselves to examine and allow for the part that environment plays.

REGRESSION IN THE ANALYTIC SITUATION

I now want to go directly to Freud, and I want to make a somewhat artificial distinction between two aspects of Freud's work. We see Freud developing the psycho-analytic method out of the clinical situation in which it was logical to use hypnosis.

FREUD'S OWN TECHNIQUE

(a) Choice of Case

Let us look and see what Freud did in choosing his cases. We can say that out of the total psychiatric pool, which includes all the mad people in asylums as well as those outside, he took those cases which had been *adequately provided for in earliest infancy*, the psycho-neurotics. It might not be possible to confirm this by a close examination of the early cases on which Freud did work, but of one thing we can be certain, and this is most important, that Freud's own early personal history was of such a kind that he came to the Oedipus or prelatency period in his life as a whole human being, ready to meet whole human beings, and ready to deal in interpersonal relationships. His own infancy experiences had been good enough, so that in his self-analysis he could take the mothering of the infant for granted.

Freud takes for granted the early mothering situation and my contention is that *it turned up in his provision of a setting for his work*, almost without his being aware of what he was doing. Freud was able to analyse himself as an independent and whole person, and he interested himself in the anxieties that belong to interpersonal relationships. Later of course he looked at infancy theoretically and postulated pregenital phases of instinct development, and he and others proceeded to work out details and to go further and further back in the history of the individual. This work on the pregenital phases could not come to full fruition because it was not based on the study of patients who needed to regress in the analytic situation.[2]

(b) The Two Aspects

Now I wish to make clear in what way I artificially divide Freud's work into two parts. First, there is the technique of psycho-analysis as it has gradually developed, and which students learn. The material presented by the patient is to be *understood* and to be *interpreted*. And, second, there is the *setting* in which this work is carried through.

THE SETTING

Let us now glance at Freud's setting. I will enumerate some of the very obvious points in its description.

1. At a stated time daily, five or six times a week, Freud put himself at the service of the patient. (This time was arranged to suit the convenience of both the analyst and the patient.)

---

2 You will observe that I am not saying that this theoretical work on pregenital instinct could not succeed on account of a lack in Freud of direct contact with infants, because I see no reason why Freud should not have had very good experience as an observer of the mother-infant situation within his own family and his work. Further I am reminded that Freud worked in a children's clinic and made detailed observation on infants when studying Little's disease. The point that I wish to make here is that *fortunately* for us Freud found his interest at the beginning not in the patient's need to regress in the analysis but in what happens in the analytic situation when regression is *not* necessary and when it is possible to take for granted the work done by the mother and by the early environmental adaptation in the individual patient's past history.

2. The analyst would be reliably there, in time, alive, breathing.
3. For the limited period of time prearranged (about an hour) the analyst would keep awake and become preoccupied with the patient.
4. The analyst expressed love by the positive interest taken, and hate in the strict start and finish and in the matter of fees. Love and hate were honestly expressed, that is to say not denied by the analyst.
5. The aim of the analysis would be to get into touch with the process of the patient, to understand the material presented, to communicate this understanding in words. Resistance implied suffering and could be allayed by interpretation.
6. The analyst's method was one of objective observation.
7. This work was to be done in a room, not a passage, a room that was quiet and not liable to sudden unpredictable sounds, yet not dead quiet and not free from ordinary house noises. This room would be lit properly, but not by a light staring in the face, and not by a variable light. The room would certainly not be dark and it would be comfortably warm. The patient would be lying on a couch, that is to say comfortable if able to be comfortable, and probably a rug and some water would be available.
8. The analyst (as is well known) keeps moral judgement out of the relationship, has no wish to intrude with details of the analyst's personal life and ideas, and the analyst does not wish to take sides in the persecutory systems even when these appear in the form of real shared situations, local, political, etc. Naturally if there is a war or an earthquake or if the king dies the analyst is not unaware.
9. In the analytic situation the analyst is much more reliable than people are in ordinary life; on the whole punctual, free from temper tantrums, free from compulsive falling in love, etc.
10. There is a very clear distinction in the analysis between fact and fantasy, so that the analyst is not hurt by an aggressive dream.
11. An absence of the talion reaction can be counted on.
12. The analyst survives.

ANALYST BEHAVES

A good deal more could be said, but the whole thing adds up to the fact that the analyst *behaves* himself or herself, and behaves without too much cost simply because of being a relatively mature person. If Freud had not behaved well he could not have developed the psycho-analytic technique or the theory to which the use of his technique led him. This is true however clever he might at the same time have been. The main point is that almost any one detail can be found to be of extreme importance at a specific phase of an analysis involving some regression of the patient.

There is rich material here for study, and it will be noted that there is a very marked similarity between all these things and the ordinary task of parents, especially that of the mother with her infant or with the father playing a mother role, and in some respects with the task of the mother at the very beginning.

Let me add that for Freud there are three people, one of them excluded from the analytic room. If there are only two people involved then there has been a regression of the patient in the analytic setting, and the setting represents the mother with her technique, and the patient is an infant. There is a further state of regression in which there is only one present, namely the patient, and this is true even if in another sense, from the observer's angle, there are two.

THESIS

My thesis up to this point can be stated thus:

A. Psychotic illness is related to environmental failure at an early stage of the emotional development of the individual. The sense of futility and unrealness belongs to the development of a false self which develops in protection of the true self.
B. The setting of analysis reproduces the early and earliest mothering techniques. It invites regression by reason of its reliability.
C. The regression of a patient is an organized return to early dependence or double dependence. The patient and the setting merge into the original success situation of primary narcissism.
D. Progress from primary narcissism starts anew with the true self able to meet environmental failure situations without organization of the defences that involve a false self protecting the true self.

E. To this extent psychotic illness can only be relieved by specialized environmental provision interlocked with the patient's regression.

F. Progress from the new position, with the true self surrendered to the total ego, can now be studied in terms of the complex processes of individual growth.

In practice there is a sequence of events:

1. The provision of a setting that gives confidence.
2. Regression of the patient to dependence, with due sense of the risk involved.
3. The patient feeling a new sense of self, and the self hitherto hidden becoming surrendered to the total ego. A new progression of the individual processes which had stopped.
4. An unfreezing of an environmental failure situation.
5. From the new position of ego strength, anger related to the early environmental failure, felt in the present and expressed.
6. Return from regression to dependence, in orderly progress towards independence.
7. Instinctual needs and wishes becoming realizable with genuine vitality and vigour.

All this repeated again and again.

PSYCHOSIS: ORGANIZED OR CHAOTIC

Here a comment must be made on the diagnosis of psychosis.

In consideration of a group of mad people there is a big distinction to be drawn between those whose defences are in a chaotic state, and those who have been able to organize an illness. It must surely be that when psycho-analysis comes to be applied to psychosis it will be more likely to succeed where there is a highly organized illness. My own personal horror of leucotomy and suspicion of E.C.T. derives from my view of psychotic illness as a defensive organization designed to protect the true self; and also, from my feeling that apparent health with a false self is of no value to the patient. Illness, with the true self well hidden away, however painful, is the only good state unless we can go back with the patient as therapists and displace the original environmental-failure situation.

CLINICAL REGRESSION AND FLIGHT TO SANITY

Another consideration follows naturally here. In a group of psychotic patients there will be those who are clinically regressed and those who are not. It is by no means true that the clinically regressed are the more ill. From the psycho-analyst's point of view it may be easier to tackle the case of a patient who has had a breakdown than to tackle a comparable case in a state of flight to sanity.

It takes a great deal of courage to have a breakdown, but it may be that the alternative is a *flight to sanity*, a condition comparable to the manic defence against depression. Fortunately in most of our cases the breakdowns can be caught within the analytic hours, or they are limited and localized so that the social milieu of the patient can absorb them or cope with them.

ELUCIDATION

A. To clarify the issue I wish to make a few comparisons. The couch and the pillows are there for the patient's use. They will appear in ideas and dreams and then will stand for the analyst's body, breasts, arms, hands, etc., in an infinite variety of ways. In so far as the patient is regressed (for a moment or for an hour or over a long period of time) the couch *is* the analyst, the pillows *are* breasts, the analyst *is* the mother at a certain past era. In the extreme it is no longer true to say the couch stands for the analyst.

B. It is proper to speak of the patient's *wishes*, the wish (for instance) to be quiet. With the regressed patient the word wish is incorrect; instead we use the word *need*. If a regressed patient *needs* quiet, then without it nothing can be done at all. If the need is not met the result is not anger, only a reproduction of the environmental failure situation which stopped the processes of self growth. The individual's capacity to 'wish' has become interfered with, and we witness the reappearance of the original cause of a sense of futility.

C. The regressed patient is near to a reliving of dream and memory situations; an acting out of a dream may be the way the patient discovers what is urgent, and talking about what was acted out follows the action but cannot precede it.

D. Or take the detail of being on time. The analyst is not one who keeps patients waiting. Patients dream about being kept waiting and all the other variations on the theme, and they can be angry when the analyst is late. This is all part of the way the material goes. But patients who

regress are different about the initial moment. There come phases when everything hangs on the punctuality of the analyst. If the analyst is there ready waiting, all is well—if not, well then both analyst and patient may as well pack up and go home, since no work can be done. Or, if one considers the patient's own unpunctuality, a neurotic patient who is late may perhaps be in a state of negative transference. A depressive patient is more likely by being late to be giving the analyst a little respite, a little longer for other activities and interests (protection from aggression, greed).

The psychotic (regressive) patient is probably late because there is not yet established any hope that the analyst will be on time. It is futile to be on time. So much hangs on this detail that the risk cannot be taken, so the patient is late; therefore no work gets done.

E. Again, neurotic patients like to have the third person always *excluded*, and the hate roused by sight of other patients may disturb the work in unpredictable ways. Depressive patients may be glad to see other patients till they reach the primitive or greedy love, which engenders their guilt. Regressive patients either have no objection to there being other patients or else they cannot conceive of there being another patient. Another patient is none other than a new version of the self.

F. A patient curls up on the couch and rests the head on the hand and seems warm and contented. The rug is right over the head. The patient is alone. Of course we are used to all varieties of angry withdrawal, but the analyst has to be able to recognize this *regressive* withdrawal in which he is not being insulted but is being used in a very primitive and positive way.

G. Another point is that regression to dependence is part and parcel of the analysis of early infancy phenomena, and if the couch gets wetted, or if the patient soils, or dribbles, we know that this is inherent, not a complication. Interpretation is not what is needed, and indeed speech or even movement can ruin the process and can be excessively painful to the patient.

THE OBSERVER SELF

An important element in this theory is the postulate of the observing ego. Two patients very similar in their immediate clinical aspect may be very different in regard to the degree of organization of the observer ego. At one extreme the observing ego is almost able to identify with the analyst and there can be a recovery from the regression at the end of the analytic hour. At the other extreme there is very little observing ego, and the patient is unable to recover from the regression in the analytic hour, and must be nursed.

ACTING OUT

Acting out has to be tolerated in this sort of work, and with the acting out in the analytic hour the analyst will find it necessary to play a part, although usually in token form. There is nothing more surprising both to the patient and to the analyst than the revelations that occur in these moments of acting out. The actual acting out in the analysis is only the beginning, however, and there must always follow a putting into words of the new bit of understanding. There is a sequence here:

1. A statement of what happened in the acting out.
2. A statement of what was needed of the analyst. From this can be deduced:
3. What went wrong in the original environmental failure situation.

This produces some relief, but there follows:

4. Anger belonging to the original environmental failure situation. This anger is being felt perhaps for the first time, and the analyst may now have to take part by being used in respect of his failures rather than of his successes. This is disconcerting unless it is understood. The progress has been made through the analyst's very careful attempt at adaptation, and yet it is the *failure* that at this moment is singled out as important on account of its being a reproduction of the original failure or trauma. In favourable cases there follows at last:
5. A new sense of self in the patient and a sense of the progress that means true growth. It is this last that must be the analyst's reward through his identification with his patient. Not always will a further stage arrive in which the patient is able to understand the strain which the analyst has undergone and is able to say thank-you with real meaning.

ENVIRONMENTAL ADAPTATION AND STRAIN

This strain on the analyst is considerable, especially if lack of understanding and unconscious negative countertransference complicates the picture. On the other hand, I can say that in this particular treatment I have never felt bewildered, and this is to some extent a compensation. The strain can be quite simple.

In one vitally important hour near the beginning of the treatment I remained and knew I must remain absolutely still, only breathing. This I found very difficult indeed, especially as I did not yet know the special significance of the silence to my patient. At the end the patient came round from the regressed state and said: 'Now I know you can do my analysis.'

ORGANIZED REGRESSION TO DEPENDENCE

The idea is sometimes put forward: of course everyone wants to regress; regression is a picnic; we must stop our patients from regression; or, Winnicott likes or invites his patients to regress.

Let me make some basic observations on the subject of organized regression to dependence.

1. This is always extremely painful for the patient,

a. at one extreme is the patient who is fairly normal; here pain is experienced almost all the time;

b. midway we find all degrees of painful recognition of the precariousness of dependence and of double dependence;

c. at the other extreme is the mental hospital case; here the patient presumably does not suffer at the time on account of dependence. Suffering results from sense of futility, unrealness, etc.

This is not to deny that in a localized way extreme satisfaction can be derived from the regression experience. This satisfaction is not sensuous. It is due to the fact that regression reaches and provides a starting-place, what I would call a *place* from which to operate. The self is reached. The subject becomes in touch with the basic self-processes that constitute true development, and what happens from here is felt as real. The satisfaction belonging to this is so much more important than any sensuous element in the regression experience that the latter need not be more than mentioned in this connection.

2. There are no reasons why an analyst should *want* a patient to regress, except grossly pathological reasons. If an analyst likes patients to regress, this must eventually interfere with the management of the regressed situation. Further, psycho-analysis which involves clinical regression is very much more difficult all along than that in which no special adaptive environmental provision has to be made. In other words it would be pleasant if we were to be able to take for analysis only those patients whose mothers at the very start and also in the first months had been able to provide good enough conditions. But this era of psycho-analysis is steadily drawing to a close.

ANALYSTS' REACTIONS TO LOCALIZED REGRESSIONS

But the question arises, what do analysts do when regression (even of minute quantity) turns up?

1. Some crudely say: Now sit up! Pull your socks up! Come round! Talk! etc.

But this is not psycho-analysis.

2. Some divide their work into two parts, though unfortunately they do not always fully acknowledge this:

a. they are strictly analytic (free association in words; interpretation in words; no reassurances); and also

b. they act intuitively.

Here comes the idea of psycho-analysis as an *art*.

3. Some say: unanalysable, and throw up the sponge. A mental hospital takes over.

The idea of psycho-analysis as an art must gradually give way to a study of environmental adaptation relative to patients' regressions. But while the scientific study of environmental adaptation is undeveloped, then I suppose analysts must continue to be artists in their work. An analyst may be a good artist, but (as I have frequently asked): what patient wants to be someone else's poem or picture?

CAUTION

I know from experience that some will say: all this leads to a theory of development which ignores the early stages of the development of the individual, which ascribes early development to environmental factors. This is quite untrue.

In the early development of the human being the environment that behaves well enough (that makes good enough active adaptation) *enables personal growth to take place*. The self processes then may continue active, in an unbroken line of living growth. If the environment behaves not well enough, then the individual is engaged in reactions to impingement, and the self processes are interrupted. If this state of affairs reaches a quantitative limit the core of the self begins to get protected; there is a hold-up, the self cannot make new progress unless and until the environment failure situation is corrected in the way I have described. With the true self protected there develops a false self built on a defence-compliance basis, the acceptance of reaction to impingement. The development of a false self is one of *the most successful defence organizations* designed for the protection of the true self's core, and its existence results in the sense of futility. I would like to repeat myself and to say that while the individual's operational centre is in the false self there is a sense of futility, and in practice we find the change to the feeling that life is worth while coming at the moment of shift of the operational centre from the false to the true self, even before full surrender of the self's core to the total ego.

From this one can formulate a fundamental principle of existence: that which proceeds from the true self feels real (later good) whatever its nature, however aggressive; that which happens in the individual as a reaction to environmental impingement feels unreal, futile (later bad), however sensually satisfactory.

REGRESSION AND REASSURANCE

Lastly, let us examine the concept of regression by putting up against it the concept of reassurance. This becomes necessary because of the fact that the adaptive technique that must meet a patient's regression is often classed (wrongly, I am sure) as reassurance.

We assume that reassurance is not part of the psycho-analytic technique. The patient comes into the analytic setting and goes out of it, and within that setting there is no more than interpretation, correct and penetrating and well-timed.

In teaching psycho-analysis we must continue to speak against reassurance.

As we look a little more carefully, however, we see that this is too simple a language. It is not just a question of reassurance and no reassurance.

In fact, the whole matter needs examination. What is a reassurance? What could be more reassuring than to find oneself being well analysed, to be in a reliable setting with a mature person in charge, capable of making penetrating and accurate interpretation, and to find one's personal process respected? It is foolish to deny that reassurance is present in the classical analytic situation.

The whole set-up of psycho-analysis is one big reassurance, especially the reliable objectivity and behaviour of the analyst, and the transference interpretations constructively using instead of wastefully exploiting the moment's passion.

This matter of reassurance is much better discussed in terms of *countertransference*. Reaction formations in the behaviour of the analyst are harmful not because they appear in the form of reassurances and denials but because they represent repressed unconscious elements in the analyst, and these mean limitation of the analyst's work.

What would be said of an analyst's *inability* to reassure? If an analyst were himself suicidal? *A belief in human nature and in the developmental process exists in the analyst* if work is to be done at all, and this is quickly sensed by the patient.

There is no value to be got from describing regression to dependence, with its concomitant environmental adaptation, in terms of reassurance, just as there is a very real point in considering harmful reassurance in terms of countertransference.

PRACTICAL APPLICATIONS

What, if anything, am I asking analysts to do about these matters in their practical work?

1. I am *not* asking them to take on psychoti patients.
2. Nothing I have said affects the principles of ordinary practice in so far as

a. the analyst is in the first decade of his analytic career;

b. the case is a true neurotic (not psychotic).

3. I do suggest that while analysts are waiting to be in a position, through their increasing personal experience, to tackle a case in which regression must occur, there is much they can do to prepare themselves. They can:

a. watch the operation of setting factors;

b. watch the minor examples of regression with natural termination that appear in the course of analytic sessions, and

c. watch and use the regressive episodes that occur in the patient's life outside analysis, episodes, I may say, which are usually wasted, much to the impoverishment of the analysis.

The main result of the ideas I am putting forward, if they are accepted, will be a more accurate rich and profitable use of the setting phenomena in ordinary analyses of non-psychotics, resulting, I believe, in a new approach to the understanding of psychosis, and its treatment by psycho-analysts doing psycho-analysis.