Regression to Malignant Relations

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Her face freezes. I know now that I have said something totally wrong. I feel a pang of fear in my body. She begins to scream, to hit me with her words. I tell her to stop but to no avail. I am to be exterminated because I was not accurate, because I did not match her expectation to say exactly what she wished me to say. Her rage is imbued with the strict belief that only a perfect fit would save her from her miseries. Her words become harsher, her lips spit anger and cold rage and cruelty creeps into her voice.

I feel a heavy brick on my chest, I can't think. I stare at her with disbelief, beaten by her words and overwhelmed by their sound. She then gets up in a majestic disgust and leaves in yet another 'grande sortie', as we already call it. She slams the door so loudly that although expected, it sends a horrible jolt through my body and mind: I am shocked, beaten, ashamed of my impotence and failure, responsible and guilty again for a catastrophe beyond my comprehension. I become mad. After all the working through, can't she control herself? No, she cannot, and does not want to. This patient, when in need - hates herself and whoever hurts her, becomes cruel and violent, breaking furniture, dishes, and of course – me, the therapy, just as she was endlessly mentally 'broken' as a child. No matter how much I adjust myself to her, talk to her on the phone between sessions, add sessions, meet her daily when she is suicidal, being empathic to the violent impact of my failures - each rupture evokes

this turmoil. The roles between us are reversed (1): she is just as sadistic as her mother and brother were to her in her childhood.

But she is dissociated, both from her violence and from her rage: although she acts violently, she does *not feel* angry, but rather overwhelmed, shocked, and that she must flee to save herself from *my* cruelty, *my* indifference, my distance, my living in a whole different world, - envious of me for having all that she does not, protesting against this profound injustice and feeling helplessly entitled to have me merged with her and provide all her needs. She is desperately devastated because I can't even imagine what it is like to be such an outcast, almost a bag lady. Finally, she feels that I gloat at her, happy not to be in her situation.

And me? Though I manage to say the right words, how come I am always bit by a painful sting of guilt that I do, actually, neglect her? She is right; I am the therapist, it's my responsibility. I am her present 'undertaker' (2), the neglecting and cruel mother, enjoying her only when she is nice and bright and funny. And haven't I learned to expect these outbursts? I did, to a point, but never enough.

We *both* regress to our individual malignant relations, and are stuck there again and again. I know that these attacks annihilate not only me, but first and foremost her dread of falling into a gap which is, for her, an abyss. Her demand for clinging to me and for my absolute and total provision and adaptation to her are the only way *to annihilate her own annihilation anxiety*. As for myself, I am paralyzed when screamed at, just as I had been long, long ago, and I can't change this, although I am aware of the fact that when I cringe into myself I immediately become her depressed

and deserting mother, enraging her even more. This whole drama is enacted and lived out in the present. Is this 'malignant regression'?

The vignette is an illustration of what I would like to explore today – a portrayal of the so called 'malignant regression' as a *mutual enactment of dissociated self states*, which originate in early traumatic environmental failures of *primary malignant relations*.

Before the ego and its functions are established, (what Ferenczi called) the tender psyche is dependent on the environment for its survival and realization of its inborn potentials. Excessive environmental failures at this early stage of dependence arouse annihilation anxiety, which automatically evokes fragmentation and dissociation that are imprinted upon the tender psyche. The only way to survive and to maintain the crucial connection to the caretaker entails cutting itself off from its spontaneous subjectivity.

I consider any early environment as malignant if it is imbued with excessive absence of a good enough adaptation to the infant's psychic needs. Ferenczi's concept of Identification with the Aggressor sheds light on this idea. He postulated, as did Winnicott later on, that before developing ego functions, the tender psyche reacts to external threatening absence by coercively identifying with the aggressor's denial of its subjectivity and dissociating from its impact. The anxiety-ridden identification (or incorporation) is *with the annihilation of the authentic and subjective self*, and *not* as Anna Freud understood it – identification with the aggressiveness of the aggressor.

Such early absence is violent and aggressive. It forces the tender psyche to distort itself intra-psychically while adapting to the environment in order to survive the annihilation anxiety that is aroused. The dear price of such survival is fragmentation and dissociation of the authentic self.

I would like to underscore the intra-psychic rupture as the *psychic trauma.* What is traumatic is not the external event, which may be very subtle, but the deep inevitable impact of rupture and annihilation anxiety and consequently - fear of breakdown. The psyche develops around this core. Survival modes are repeated compulsively in actual relations, *not as 'malignant regression', but, as I suggest, as enactments of early malignant relations.*

At this point, let me go back to Michael Balint's concept of 'malignant regression', (3) which has bothered me for years: what is it that is malignant?

Malignant is not 'benign', and essentially different from benign regression, where, according to Balint, the basic fault (the psychic trauma) can be activated and healed by the analyst's participation. This may be attained by recognizing the patient's internal life and unique individuality without the patient's expectation for actual change in the environment. In a quiet state of 'arglos' (4)– as Balint named this satisfactory situation, a new beginning occurs: a guileless, innocent, unsophisticated, and unsuspecting attitude, which offers significant opportunities for therapeutic work (arglos is a German word with no English equivalent).

The above vignette is definitely not 'benign.' It fits Balint's description of patients in 'malignant regression', as those who "can never have enough" (5), and "if the expectations are not or cannot be met, what follows is unending suffering or unending vituperation" (6) and actual gratification of instinctual wishes must occur. The mutually trusting relationship breaks down repeatedly - there develops an addiction-like state, a constant demand for concrete gratification by the analyst. This, according to Balint, is malignant. But is it? And why does this happen?

Balint, an analysand and follower of Ferenczi, cautions us from malignant regression, alarmed by Ferenczi's relations with his most difficult patients, by his mutuality and deep involvement. Balint sought a way out by making this distinction, releasing the analyst from plunging into such 'messy' and seemingly 'non-analytic' technique. What he saw as benign regression can happen, but so often and with so many patients we do find ourselves entangled in stifling impasses and enactments where no 'new beginning' is seen in the horizon, just as Ferenczi described it in his clinical diary. The analyst inevitably becomes 'the undertaker', the retraumatizing other, by committing the same failure that the patient had barely survived in the past.

Even if the analyst is unaware of it, there is always a grain of truth in any delusion of the patient about him. In Winnicott's view, the analyst cannot avoid failing in the way that for the patient repeats early environmental failure. These failures in the actual analytic relations compulsively repeat past survival modes, protecting the dissociated traumatized parts from a return of the initial breakdown.

The malignant failures are also repeated intra-psychically: I go back here to Ferenczi's bold assumption, that if an early aggressor is incorporated into the tender psyche, it keeps its annihilating work internally, annihilating any arousal of the dissociated authentic self, which relentlessly seeks reparation. The analytic situation activates and 'invites' the dissociated parts by raising the never lost hope that some Other will safely revive them. There is, therefore, a crucial importance to actual failures in analysis: *not only are they inevitable, but they are essential for the process of reviving, via enactment, the dissociated states of early malignant relations.*

Contrary to Balint, both Ferenczi and Winnicott highlight these failures in analysis as the main opportunity for reparation, assuming that the analyst does take responsibility for them in recognition of their traumatizing impact on the patient. Ferenczi wrote: "*It is this confidence that establishes the contrast between the present and the unbearable traumatogenic past,* the contrast which is absolutely necessary for the patient in order to enable him to re-experience the past no longer as hallucinatory reproduction but as an objective memory" (7). In other words, the past will be experienced in the present, the past *is occurring* in the present, but free of coerced survival dissociation.

This road is not followed easily: if pathological dissociation is an intersubjective phenomenon (8), matters become complex, since the analyst is drawn into these enactments with his own inevitable dissociated states. Patient and analyst repeatedly get stuck in those mutual enactments, both subjugated to a malignant 'analytic third' (rephrasing Ogden's concept), with no 'arglos' to envelope any of them.

I suggest that what is called malignant regression is an enactment of psychic modes of surviving the absence of conditions that facilitate the initial continuity of being. The unending demands of the patient are manifestations of the dissociated suffering instigated by the refusal of the analyst to actually change the environment, a gratification seen by the patient as his only salvation.

For instance, the need to concretely cling to the analyst is a reaction to a trauma, an expression of and a defense against the fear of being dropped or abandoned – that had already happened. It is therefore a secondary phenomenon, whose aim is to restore, by proximity and touch, the original absent primary object (9). Incessant and desperate clinging (10) is a defense against an earlier traumatic breakdown. It expresses simultaneously what is still needed and what was traumatically absent, i.e. - an environment that enables primary clinging (11) and a normal developmental course of 'weaning' from it. Any recurrence of such threat arouses a vehement and forceful demand to diminish the recurrence of this catastrophic absence by clinging.

For the traumatized patient the analyst is responsible for those enactments. His attitude determines whether what develops will be benign regression or the repetition of malignant relations (12). According to Balint, Ferenczi's and Winnicott's theory of regression to dependence – a regressed patient needs the analyst to be with him in a state of at-one-ment, as he regresses to a stage where he is incapable of differentiating internal from external reality. The other is perceived only as a subjective object, as a function that either adapts to his needs or doesn't.

If the analyst does not realize this he literally is a traumatizing object, whose separateness would be beyond the patient's capacity to contain; the patient regressed to dependence cannot contain too much 'not me' which initially breached his continuity of being. If the analyst does not understand and recognize this regression and tries to 'organize' or explain it - the greater is the danger of the analyst *becoming* an actual aggressor, arousing in the patient fear of breakdown and repeating early malignant relations. The analyst must recognize such situations as his own failures, to be repaired by reconnecting with the patient (13). Only this adaptation by the analyst will enable the patient to experience the failure without surviving it by dissociation.

Such adaptation does not mean total adjustment, but rather a recognition of the impact of its absence. These are actual reparations of the analyst as an adaptive environment that acknowledges contained failures, and can transform them into 'benign traumas' (14), in which *experiencing* the failure revitalizes spontaneous reactions such as pain, anger and protest. Otherwise, the patient is retraumatized by the analyst and immediately casts him as part and parcel of his repeated *malignant relations*.

The imprint of early malignant relations is profound and resists change for any of the following reasons:

1. Imprinted fragmentation and dissociation: Before the ego is established, early excessive environmental failures are *imprinted and dissociated* without any mental apparatus to regulate, contain and represent it. Ferenczi wrote: "Individuals at the beginning of their existence still have totally different ways of reacting from those in later life…in infants…protective devices are not yet developed, so that infants communicate with the environment on a much broader surface… (it) has been

insufficiently appreciated that identification (is) a stage preceding object relations…a state in which any act of self-protection or defense is excluded and all external influence remains an impression without any internal anti-cathexis…people at the beginning their of lives have as yet no individuality…this kind of mimicry, this being subject to impressions without any self-protection, is the original form of life…" (15).

The tender permeable psyche is suggestible to external influence and cannot assert itself without a good-enough adaptation of the environment to its own needs. Furthermore, to realize itself, it depends on the environment. An environmental fault ruptures the psyche, and is imprinted in the psyche as a basic fault, a negative imprint of the external traumatic absence of adaptation. When annihilation anxiety is aroused, these primary identification and mimicry operating at this stage of dependence, automatically enhance the incorporation of the caretaker's attitude or absence of attitude, forcing internal distortions in order to maintain and preserve the crucial dependence on the object. This is an anxiety-ridden incorporation which results in coerced identification with the external environment's annihilation of the tender psyche's subjective existence, which is automatically fragmented and dissociated (16).

This, again, according to Ferenczi (17), is the Identification with the Aggressor. *Psychic trauma is not the external event or absence, but rather its automatic intra-psychic impact of a dissociated rupture of the continuity of being. This rupture does not cease to exist at the core of the psyche. Moreover, being imprinted, the traumatizing impingements are manifested by the survival modes which are thus a*

negative of the traumatic occurrence. (This does not mean negation or negativity, but rather what occurred as a consequence of it).

2. Compulsion to repeat: The tender psyche survival modes of fragmentation and dissociation are ruled not by the pleasure principle, but by *the compulsion to repeat and act-out dissociated parts* (18).

These dissociated states are unrepresented (19), inaccessible to any mental association. Yet they are in a relentless struggle to be revived and are acted out and manifested in mutual enactments in the inter-subjective field and intra-psychically. Fear of breakdown rules this 'psychic equilibrium' and overshadows and forbids any tapping of the unbearable annihilating anxiety. Even when the analyst provides a safe environment for the dissociated parts to revive, the internal incorporated aggressor threatens the psyche by fear of recurrent return of the past trauma, and the analyst is inevitably regarded as a potential aggressor who will repeat the initial breakdown. *The past is alive in the present*.

The analyst must be alert to this paradoxical attitude of the patient, and attend to its manifestations in the actual analytic relations, thus providing him with a good enough adaptation, which facilitates a continuity of being. This does not mean incessant satisfaction, but rather a good enough adaptation which creates basic trust and attachment that can contain and experience failures *without dissociation*, and thus – growth and development.

3. Dissociated 'me-states' that are sensed as 'not-me': The incorporated malignant relations (or identification with the aggressor) continuously threaten the authentic self with the return of breakdown, keeping authentic 'me-states' dissociated in a pathological state and regarded as 'not me states'. This is a self mutilation that runs along a continuum beginning with self reproaches – not for doing something bad or wrong, but for *being defective, sensing oneself as flawed and faulty*, annihilation of any authentic self state, up to physical self mutilation, and even suicide. Shame and guilt *for having* a self are mingled with the fear of breakdown if revived. This is the incorporated external annulment of the self, which is repeatedly and compulsively activated when dissociated spontaneous states of the true self are aroused. Then they may be sensed as 'being mad'. Furthermore, "feelings of hatred are thereupon directed against all emotions including hate itself, and against external reality which stimulates them. It is a short step from hatred of the emotions to hatred of life itself" (20).

4. 'Alien transplants' - 'not-me' states experienced as 'me': Any use of the parent of the child's psyche for his own needs, any extensive dissociation of the caretaker of the child's needs, any projection of unbearable states by the parent to the child, any accusation of the child for the caretaker's emotional difficulties – they all infiltrate into the gaps created by dissociation. The tender psyche has no defense against them. The more the caretaker uses the child, the more suggestible and permeable he becomes. In identification with the other's attitude towards him, he accepts any misconceptions and misrepresentations. These 'not-me' states of invasive objects (21), interjects (22), projections and projective identifications of the parent, are sensed as part of the self, of 'me', *though they are not*.

In Ferenczi's words, this is the fate of children whose parents use them for their own psychic needs (23): “[…in cases] that adults forcibly inject their will, particularly psychic contents of an unpleasurable nature, into the childish personality…these split-off, alien transplants vegetate in the other person during the whole of life…". Any attempt to protect the self arouses confusion and an incomprehensible fear of having killed or a wish to kill, to get rid of, without understanding what and why. Evacuating these alien transplants cause "a tremendous void in the person who has become accustomed to having the alien will as a skeleton of his own person…up to a state of complete dissolution". These alien transplants are infused with one's own drives - one's own psyche intertwined with the other's.

These parts, unwillingly incorporated, are "forcible introjections and embodiment of pathological internal part-objects that disrupt ego functioning and the evolution of a sense of self…" (24), which may collude with the incorporated aggressor. There may also be an overwhelming identification with an invasive rejecting object that colonizes the psyche as internal 'mafia', and repeatedly annihilates the self, arousing extreme self-reproaches and self-mutilation. Furthermore, the invaded psyche also *identifies with the invasiveness itself* and tends to expel these interjects invasively and forcefully into the analyst, who becomes overwhelmed and confused, reversing the malignant relations.

5. Unrealized authentic self and spontaneous gestures: Early malignant relations are immanent with excessive *absence* of a good-enough-environment. This absence has a traumatic impact on the tender psyche: An adequate response to early spontaneous gestures is crucial for the development of a sense of being, of being real,

of being a subject. Inborn potentials that have not been adequately responded to and have not been materialized stay frozen, yet strive for a providing environment in order to revive. The question, at this point, is what happens to spontaneous gestures if they do not meet an adequate response? Do they 'simply' stay frozen?

The breakdown of the mother's reverie or holding floods the psyche with unbearable primary agonies or nameless dread, and automatically raise a need to 'short-circuit' (25) these breaches. They are embedded in an absence of attachment of the caretaker and in his dissociation of its internal catastrophe for the child. This external dissociation from the intra-psychic impact of the impingement on the tender psyche is imprinted as an internal dissociation. I call this state "absence within absence". What we meet is its *negative*, that is – the mode that the psyche survived this crucial absence. What does that mean?

The establishment of a sense of real depends on the actual realization of finding in reality what was created in the psyche. The inborn expectations need to actually to be met in order to experience, imagine, and transform them into a representation (26). The unmet spontaneous gesture (27) actually ruptures and hinders the development of a sense of real and of transition from relating to objects as subjectively perceived to recognizing them as external and objective. As a result, the striving for realness never stops. It is felt as deadness, de-realization, de-personalization and the like, which are actually the negative manifestations of this initial failure and embody its residues and consequences (28).

When absence occurs and lasts beyond the capacity to contain it, and the mother is dissociated from the threat to the tender psyche – it is overcome by nameless dread, with no representation. When revived in analysis by the analyst's reverie, the *unrepresented absence is experienced as more real* than any external or internal object or fact. Winnicott quotes a patient who was separated from her parents at an early age (29), while referring to a former analyst; the analyst's presencing of the absence, both external and internal, allowed the patient to experience that: 'The negative of him is more real than the positive of you'. To this he adds, that she managed never to call by name those who were caring for her the whole of those years, and that this was the negative of the dissociated memory of her father and mother.

6. Survival modes of nameless dread: What all of this means is that when the mother's reverie is absent, there can be no representation of a bad or absent object or experience. Absence of representation is filled with unbearable nameless dread which activates other psychic survival functions; this internal absence is not empty. Bion suggests that it is transformed into other reparative hallucinations such as clinging to an 'unceasing breast' as the only way to survive.

The psyche needs 'do' something about this unrepresented absence, and will employ various mental 'tools' to deal with this missing function: Sexualization, somatization, perversion, psychosis are also possibilities for surviving these tensions (30). These are alternatives for patterns of deficient attachment (31), and are all psychic phenomena alluding to a dissociated primary trauma.

These survival modes offer a pathological solution, a concreteness devoid of symbolization and of normal representations (32). They are negative manifestation which 'stich' (33) and 'cover' the scars of absence and are an attempt to fill this dreaded gap or rupture while actually leaving the original wound inaccessible.

7. Hallucinatory salvation as a reverse of malignant relations: Although dissociated, the dissociated psychic retreats keep activating the psyche. Ferenczi describes in his diary (p.19) that they also evoke "protest against violence and injustice, contemptuous, perhaps sarcastic and ironic obedience displayed in the face of domination; but inward knowledge that the violence has in fact achieved nothing; it has altered only something objective (meaning external behavior), the decision-making process, but not the ego (true self here) as such. Contentment with oneself for this accomplishment, a feeling of being bigger and cleverer than the brutal force; suddenly insight into the greater coherence of world order, the treatment of brute force as a kind of mental disorder, even when this power is successful".

This sense of omnipotence may or may not be dissociated, yet it is always oblivious to the reality that the very fragmentation of the psyche and the need to survive it has already occurred and that these survival means are sealed in psychic retreats and have no means for realization. They may keep sanity and true self protected, but have no ability to revive them in real and actual intersubjective relations (34). Had there been a mother's reverie, anxiety would have been relieved not by an incessant breast but rather by adaptive feeding and soothing the anxiety.

When this function is traumatically absent, the internal absence may also be filled with reparative hallucinations such as clinging to an 'unceasing breast'. These hallucinatory salvations aim to annihilate annihilating anxiety, and promote a sense of omnipotence, oblivious of the fragmented psyche's painful reality.

These are "permanent enclaves ...that unconsciously commemorate traumatic episodes in the patient's earlier history"(34, p.146). These phenomena propose *to reverse* (36) the conditions that caused the psychic catastrophe: If it were a result of not enough holding, the only fantasyed (35) cure can be that of incessant clinging; if an absence of holding aroused feelings of emptiness, then one has to constantly fill it up by an 'unceasing breast', etc.

In this situation, the excessive absence of a good breast is used by the tender psyche to regard the anxiety arousing from it as incessant hunger for which an incessant breast would be the only relief. This psychic state "seems to be the mirror image (a negative) of the sane one…sanity in reverse, "topsy-turvy, "a mock-up of it, a sinister, eerie, bizarre imitation of it. This imitation… is actually transformations in hallucinosis (Bion 1962)" (37). Such hallucinations, which are dissociated from the psycho-somatic matrix, have no access to materializing in reality. Nevertheless, they *contain a grain of the initial absence* and the wish to repair it by avoiding annihilation anxiety, and they seem and feel totally concrete and real. While Grotstein emphasizes the fictitious quality of those hallucinations (37), I suggest that they always *contain and express a dissociated acknowledgement of the traumatically initial absence in the early external environment.*

8. Enactments in analysis: These intertwined and complex qualities of surviving early malignant relations are inevitably enacted in analysis. The dissociated states seek their revival via these survival modes, in need for an other who will provide what had been absent but never given up. Basic trust in the analyst depends on the sense that he actually provides adaptation to the patient. This does not mean incessant satisfaction but rather adaptation to the patient's needs according to the analyst's ability. Needed adaptive changes in the environment do not indicate 'malignant regression' but rather the recognition of the patient's level of regression to dependence.

Failures are inevitable and crucial for making a difference between the traumatic occurrence in the past and its experience in the actual present, *without dissociation*. These enactments enable the potential cure for a ruptured self. Experiencing psychic pain may be frightening and terrible, but it is *alive*, not dissociated and psychically dead. Survival-invulnerability is transformed to human suffering. In analysis, the analyst is expected to recognize these pleas for sanity. Survival modes should not be regarded as resistance but as a path for reconstruction of dissociated schemas (38).

An analyst, threatened by the patient's regressive needs, will strive to avert them; in order to analyze a patient's regressive longings, the analyst must be comfortable with them (39), and know his own traumas. Furthermore, "the more the analyst can reduce the inequality between the patient and himself, and the more unobtrusive and ordinary he can remain in his patient's eyes, the better are chances of a benign form of regression" (40). This means that the analyst lets the patient to lead him (41), allows for the analysis to occur 'in the way of the patient' (42), and adheres to a 'technique'

that allows the patient to experience him as a subjective object without impinging on him an objective external reality that is beyond his ability to contain; This means "abandoning any attempt at 'organizing' the material produced by the patient….and tolerating it so that it may remain incoherent, nonsensical, unorganized, till the patient… will be able to give the analyst the key to understand it" (43); 'acting-out' and enactment are valid means of communication, and in these cases – the only access to dissociated parts.

The analyst needs also to offer 'something' to the patient which will fulfill functions that were not available by the primary object. What is this 'something' that functions as a primary object? In recent theories, several clinical suggestions are made concerning these states of unrepresented unconscious. They all highlight the analyst's actual role and involvement in fulfilling the absent crucial environmental functions that promote symbolization and representation.

A crucial function for reviving dissociated states is to enable to experience them and sense them as real. Ferenczi suggested (44) that "one cannot believe that an event took place if the analyst does not take really seriously the *role* one assumes, of the benevolent helpful observer, that is, actually to transport oneself into that period of the past (a practice Freud reproached me for, as being not permissible), with the result that we ourselves and the patient believe in its reality, that is, a present reality, which has not been momentarily transposed into the past". In Winnocott's terms – to experience *together* renders a sense of real to what has occurred but not experienced.

To attain this, the analyst must relinquish his 'language of passion' – his theory, his technique - and realize that his subjective responses to the patient are not necessarily projected into him but may rather be his own transference, due to his subjectivity, limitations and failures. He should agree to be receptive and honestly involved, able to see his failures in the way of the patient (their subjective impact on the patient), and understand and make contact with the patient at the present level of development of his psyche. This last point meaning, that when the patient is in a level of dependence, he can perceive the object only in a subjective way, so the analyst must acknowledge the fact that the patient is yet incapable of containing him as an external object. Interpretations *about* what is happening can be understood by the False Self, without touching the emotionally dissociated states. The analyst needs to see what is happening to the patient 'in the way of the patient', living with him the past as a present occurrence. This has 'a healing effect…the traumatized psyche feels love, cleansed of all ambivalence, flowing toward it and enveloping it, as if with a kind of glue: fragments come together into larger units; the entire personality may succeed in again becoming united' (45).

9. Mutual dissociation in enactments: Theoretical literature concerning these issues acknowledge the intersubjective quality and mutuality of dissociated states (46), the irrelevance of verbal interpretation and the need for the analyst to meet, be with, regress mutually, be receptive etc, and to be able, through his own experience to provide a reverie function for the patient's dissociated states. These ideas introduce the importance of the analyst's attitude as crucial for determining whether traumatic environment will be enacted as a retraumatizing event - or worked through. It is the

analyst's countertransference and transference that determines the patient's transference, and not the other way around.

This entails being involved with total immersion and opening up in a way that the analyst can detect his own dissociated states *after* they are activated in enactments. Contrary to Balint, and somewhat to Winnicott but less so, Ferenczi knew this and was not afraid to plunge into any messy relationships that evolved in analyses of deeply traumatized patients.

What happens to the analyst when drawn into the turmoil, in which his own dissociated states will inevitably come to the fore? Ferenczi is the first analyst who dared to deal theoretically and clinically with the fact that the analyst's psyche is not different from that of his patient, and that no matter how well analyzed he may be, his own dissociated states will be enacted and impinge the patient, thus repeating mutually early malignant relations.

My point here is that early malignant relations have specific attributes that enhance their hold on the mental functioning of both analyst and patient. The analyst needs to struggle through his own personal capacities, psychic pains and dissociations as well as with the patient, and 'live through' those regressions to malignant relations. Recognition of his failures and their impact on the patient is crucial, and so is his ability to transform the uncontained to an experienced failure. Explaining the patient's states as a survival reaction to an external impingement enables the patient to experience himself as reacting to external traumatizing environment and to intra-psychic annihilation anxiety. This includes a 'negative capability' of the analyst

combined with an ability to experience the patient's feelings and to help him understand the uncontained quality of the analyst as an object objectively perceived.

These explanations seem similar to self-disclosures but are different – in the sense that they are not aimed at revealing the analyst's subjectivity as such, but rather to provide an alpha-function for the patient about the analyst as an objective object which has been uncontained by the patient. This function is crucial for disentangling malignant enactments; the analyst functions for the patient as a primary object who recognizes that a rupture has occurred, and gives the patient a meaning for it, accompanied by the empathy and adaptation that have been absent in the initial trauma. The analyst thus transforms traumatic events in the present into experienced suffering, allowing for pain, protest and rage to be alive and not dissociated. In Winnicott's concepts – this is a transformation to benign trauma which is embedded in a sense of real, with differentiation between internal and external reality, representation and psychic growth.

Back to the vignette: For many years we have understood together that she has been abused, incorporated invasive objects and that they explode out of her with no control and regulation, that her dissociated protest and rage in the past were reviving, that she survived in her fantasies of grandeur which compensated for her extreme loneliness and her vulnerability, and that this fantasying (47) expressed a crucial claim for her born right and need to be special and loved. We also understood that she could not bear my own exposed vulnerability which also evoked her own rage, and in role reversal - the way her own vulnerability was cruelly treated as a child. All of this helped, but still something was missing: she kept feeling that I intentionally rejected

her neediness because it was repulsive for me, and that she deserved to be expelled and cut off because of her faulty self. My cringing and emotional paralysis when screamed at, were experienced by her as repulsion and disgust, from which she fled in total despair and rage in order to save herself.

At a certain point, the assault became unbearable for both of us. I told her that I know that my response drove her mad and aroused her rage, but that I can't do anything about my reaction, that my reaction has to do with my own abusive past, and that I repeatedly close myself, even though I know that had I put a limit to her tantrum - it would help her. I have thus let her know that I recognize my impact on her when I cringe and that I understand that she senses it as hatred and repulsion towards her. Of course, all of this was also correct and later addressed openly. But still, my initial response had personal origins that she could not have known. It was beyond her subjective capacity to know and beyond my ability to control, and it had to actually occur between us in order to be experienced by both of us.

I had not heard from her until our next meeting. She came in calm, smiling at me shyly and said: “I had the most extraordinary experience after I left. It occurred to me gradually that I had an extreme pleasure in beating you up. I feel strong. No one can beat me. No one ever will.”

Once she could experience my vulnerability and her own violence, she could paradoxically begin to comprehend her own fragility and her wish to reverse it. It took many more years of painful work for her to be able to better contain her vulnerability and violence without 'breaking' relations and "not to burn the club if it

does not suit me perfectly"; but since that session the 'grandes sorties' stopped and she never screamed at me again.

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5. Balint, Ibid, p. 138

6. Balint, ibid. p. 140

7. Ferenczi, S. 1933. Confusion of tongues between adults and the child. In Balint, M. (ed). 1955. Final contributions to the problems and methods of psyco-analysis. Basic Books, NY.

8. Phillip Bromberg is the main theorist that underscores this quality of pathological dissociation. It is an underlying assumption also for Ferenczi and Winnicott - see also Gurevich, H. 2014. The return of dissociation as absence within absence. AJP, 74(4), pp. 313-321.
For mutual dissociation of analyst and patient – see Stern, D.B. 2010. Partners in thought. Routlege, NY&London.

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For mutual dissociation of analyst and patient – see Stern, D.B. 2010. Partners in thought. Routlege, NY&London

9. Balint, Ibid. p. 145

10. Balint, M. Ibid. p. 145

11. It is only appropriate at this point to remind us of Imre Herman's theory of clinging: Herman was Ferenczi's student and a prominent analyst in Hungary. The essence of his theory was that 'the instinctive behavior of the ape infant, that is, its clinging to the mother, is an existing but inhibited instinctive drive in human infants as well… an that it can be triggered in the 3 month old infant… the clinging instinct is frustrated …since the mother's body is not hairy, and as a latent drive, it is effective throughout a human's life. It provides the biological background to the mother-infant relationship. ..and will later be a source of loving relationships, but also a source of aggressive tendencies…, particularly after a disappointment or loss of a loved one. ' he adds that the opposite of this instinct is going-in-search, 'that becomes active when the instinct of clinging is left without object of clinging. The aspirations to separate and hide oneself are…a manifestation on the instinct of clinging. These are considered to be reaction formations used by the ego as a means if defence…clinging, going-in-search, separation and hiding, including self-destruction (p141), are closely connected phenomena; Herman called them 'the clinging syndrome' (p140) which is a reaction to traumatic separation (141). In Szekacs-Weisz, J. and Keve, T. (eds). 2012. Ferenczi and his world. Karnac, London.

12. Balint, M.Ibid. P. 173

13. Ferenczi, S., 1931. Child analysis in the analysis of adults. In Balint, M. (ed). 1955. Final contributions to the problems and methods of psyco-analysis. Basic Books, NY. P. 126

14. Winnicott, D.W., 1965. The concept of trauma in relation to the development of the individual within the family. In Winnicott, C. et.al. (eds). 1989. Psychoanalytic Explorations. Karnac, London. Ch. 22

15. Dupond, Ibid. Pp. 147-148.

16. Gurevich, H. 2014. The return of dissociation as absence within absence. AJP, 74(4), pp. 313-321.

17. It is interesting to compare the concept of identification with the aggressor with Bion's obstructive object and Winnicott's good enough environment.

18. Roussillon, R. 2011. Primitive Agony and symbolization. Karnac, London. Introduction, pp. 1-26.

19. Levine, H.2014. Beyond neurosis: Unrepresented states and the construction of the mind. Revista Psicoanal., 60(2):277-294

20. In “Attacks on Linking” (1993) Bion writes:

> Projective identification makes it possible for him to investigate his own feelings in a personality powerful enough to contain them. Denial of the use of this mechanism, either by the refusal of the mother to serve as a repository for the infant's feelings, or by the hatred and envy of the patient who cannot allow the mother to exercise this function, leads to a destruction of the link between infant and breast and consequently to a severe disorder of the impulse to be curious *on which all learning depends* [emphasis added]. The way is therefore prepared for a severe arrest of development. Furthermore, thanks to a denial of the main method open to the infant for dealing with his too powerful emotions, the conduct of emotional life, in any case a severe problem, becomes intolerable. Feelings of hatred are thereupon directed against all emotions including hate itself, and against external reality which stimulates them. It is a short step from hatred of the emotions to hatred of life itself. (pp. 106-107)

21. Williams, P. 2010. Invasive objects. Routledge, NY&London.

22. Bollas, C. 1999. The mystery of things. Routledge, NY&London. P.113

23. Dupont, Ibid. 7.4.32

24. Williams, P., Ibid. pp. 13-17.

25. Ogden, T. 2014. Fear of breakdown and the unlived life. IJPA, 95 (205-223)

26. Winnicott, D.W. 1988. Human Nature, pp. 100-8. Otherwise, writes Winnicott, this is what may happen: 'Let us imagine a theoretical first feed…. There develops an expectancy, a state of affairs in which the infant is prepared to find something somewhere, not knowing what…. (if) at about the right moment the mother offers her breast. .. if the first feed goes well, contact is established… (when) the baby is ready to create, and the mother makes it possible for the baby to have the illusion that the breast…has been created by impulse out of need…the baby can begin to hallucinate the nipple (represent it) …thus starts the infant's concept of external reality… the basis for the infant's gradual recognition of a lack of magical control over external reality lies in the initial omnipotence that is made a fact by the mother's adaptive technique". This situation enables a gradual process of normal development and possibility of gradual weaning that enhances differentiation between internal and external reality.
"Per contra, if the first feed is mishandled, a great deal of trouble may be caused…a failure at this point exaggerates instead of healing a split in the person of the infant. Instead of relationship with external reality softened by the temporary use of an illusory state of omnipotence there develop two separate kinds of object-relationship…on the one hand there is the infant's capacity to create (true self)…and on the other hand there is a false self …which is passive to the demands of external reality. It is very easy

to be deceived and to see a baby responding to skilful feeding, and to fail to notice that this infant, who takes in an entirely passive way, has never created the world, and has no capacity for external relationships, and has no future as an individual".
27. Stern, D. et al. (1998. **Non- interpretive mechanisms in psychoanalytic therapy: The 'something more' than interpretation.** International Journal of Psycho-Analysis, 79:903-921) refer to the same issue in case of a failed moment: If the failure is left unrepaired, the two gravest consequences are that either a part of the intersubjective terrain gets closed off to the therapy, as if one had said ‘we cannot go there’, or even worse, a basic sense of the fundamental nature of the therapeutic relationship is put into such serious question that therapy can no longer continue (whether or not they actually stop).

28. Bion, W. 1962. The psychoanalytic theory of thinking. Int. J. Psycho-Anal., 43:306-310: In Bion's terms - the psyche's pre-conceptions expect their realization, so that they can become conceptions. He discerns between a representation of absence and the absence of representation. The normal course is to experience absence and represent it: a representation of absence occurs if the tender psyche's can experience and contain it, that is – if there is a mother's reverie of the absence, for instance – of a breast, and if there is a good breast to be compared with. A bad breast is a good breast that is absent.

29. Winnicott, D.W. 1971. Transitional objects and transitional phenomena. In playing and reality, p 26

30. Roussillon, R., Ibid.

31. See also Liotti, G. 1999. Understanding the Dissociative Processes: The Contribution of Attachment Theory. Psychoan. Inq. 19:757-783.
Liotti, G. 2004. Trauma, Dissociation, and Disorganized Attachment: Three Strands of a Single Braid. Psychotherapy: Theory, research, practice, training Vol. 41, pp. 472-486.
Liotti, G. 2012. Disorganized attachment and the therapeutic relationship with people in shattered states. In Yellin, J. & White, K. (eds) Shattered States:Disorganized Attachment and its Repair. Karnac, London. Pp. 127-156.

32. Roussillon, R. Ibid. p. 22

33. Jacques-Alain Miller. 2007. The Symptom. Issue 8.

34. These phenomena are conceptualized in different theories as fantasying, primary dissociation, psychic equilibrium of pathological organization, psychic retreats, etc. Grotstein refers to them as 'a third area' of the psyche which is dominated by primitive and concrete survival hallucinations. See Grotstein, S.J. 2002. Endopsychic structures, psychic retreats, and 'fantasying': the pathological 'third area' of the psyche. In Pereira, F.& Scharff, D.E. (eds), Fairbairn and Relational Theory. Karnac, London &NY.

35. Winnicot, D.W. 1971. Playing and reality. Pp 31-43.

36. Bion's concept of “alpha function in reverse" may shed some more light on phenomena:: "Reversal of alpha-function means the dispersal of the contact-barrier and is quite compatible with the establishment of objects with the characteristics I once ascribed to bizarre objects. …the reversal of alpha-function did in fact affect the ego and therefore did not produce a simple return to beta-elements, but objects which differ in important respects from the original beta-elements which had no tincture of the personality adhering to them. The beta-element differs from the bizarre object in that the bizarre object is beta-element plus ego and superego traces. The reversal of alpha-function does violence to the structure associated with alpha-function. … The distinction indicates the limitation of any treatment effecting changes in the personality to secondary factors for primary factors will not be altered." Bion, W. 1962. Learning from experience (p 103).
This concept refers to changes which are associated with the replacement of alpha-function by what may be described as a reversal of direction of the function. Instead of sense impressions being changed into alpha-elements for use in dream thoughts and unconscious waking thinking. In the absence of maternal alpha function psychic elements may be transformed into elements that seem like alpha elements (having representations), yet they are not: they resemble a transformation of beta elements but they loose the possibility to return to real beta-elements which have the ability to be transformed

back into alpha elements. This concept refers to changes which are associated with the replacement of alpha-function by what may be described as a reversal of direction of the function. Instead of sense impressions being changed into alpha-elements for use in dream thoughts
and unconscious waking thinking, in the absence of maternal alpha function psychic elements may be transformed into elements that seem like alpha elements (having representations), yet they are not: they resemble a transformation of beta elements but they loose the possibility to return to real beta-elements which have the ability to be transformed back into alpha elements.

See also Civirarese, G. 2015. Transformations in Hallucinosis and the receptivity of the analyst. IJPA 96(4):1091-116

37. Grotstein 1990. Nothingness, Meaninglessness, Chaos, and the Black Hole. Contemporary Psychoanalysis, 26:257-290.

38. Bucci, W. (2002). The Referential Process, Consciousness, and the Sense of Self. Psychoanal. Inq., 22:766-793

39. Coen, S.J. (2000). The Wish to Regress in Patient and Analyst. J. Amer. Psychoanal. Assn., 48:785-810.

40. Balint, Ibid. p173

41. Purcell, S. 2018 Dissociation and Duets: Aspects of Technique in the Analysis of Developmental Trauma

42. Winnicott, D.W. 1963. Dependence in infant-care, in child-care and in the psychoanalytic setting. Inter. J. Psychoan. 44, p339

43. Balint, Ibid. pp 177-179

44. Dupont, Ibid. p. 24

45. Dupont, Ibid. p 12

46. Phillip Bromberg and Donnel Stern elaborate on these ideas.

47. Winnicott, D.W. 1971. Playing and reality. In ch. 2 "Dreaming, Fantasying, and Living". Winnicott uses this concept to describe hallucinatory fantasying which is a sort of psychic retreat, a survival self-holding which attempts to avoid fear of breakdown.