

# The Therapeutic Impact of Regression \*

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## Abstract

Regression has been curiously unfashionable for many years. When a regression occurs, especially a severe regression such as during a psychotic episode, it tends to be seen as a therapeutic threat, rather than as an opportunity for releasing healing potential. The purpose of this paper is to review diverse ideas about this phenomenon and present some clinical examples based on my work at the Arbours Crisis Centre. In so doing I intend to gain a fresh perspective about the possible positive therapeutic impact of regressive events.

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# The Therapeutic Impact of Regression

Before discussing the impact of regression we need to consider what regression entails and which people are likely to regress. There are several different views of regression according to psychodynamic, psychiatric and religious models. From a psychodynamic perspective regression is a reversion or retreat to a developmentally earlier form of functioning -- mentally, emotionally, socially or behaviorally. But it should be seen that when people regress, they do not necessarily do so in all of these modalities. Some retreat emotionally or behaviorally, but not necessarily mentally. While others, like Mary Barnes, with whom I worked with at Kingsley Hall in London, seemed to completely revert to an earlier state of being. Yet, even when she was most infantile, Mary retained strong willpower as well as some capacity to meta reflect on her condition.

The question arises: is regression always an indication of madness or psychosis? Well, not necessarily, as I shall review in a moment. Yet it is often a feature with people who suffer a so called 'nervous breakdown,' where the regression is longer and deeper and tends to be connected with psychosis or schizophrenia. In this regard it is important to note that the two are not the same. Psychosis is an altered state of reality akin to a waking dream. More to the point, psychosis denotes an experience. Schizophrenia is a medical/psychiatric diagnosis or label applied to individuals who demonstrate certain signs and symptoms or engage in certain forms of rule breaking behavior. A person can be psychotic, but not schizophrenic. Or a person can be a diagnosed schizophrenic, but not psychotic.

Let me digress for a moment and mention the distinction between normality and insanity, or neurosis and schizophrenia that R. D. Laing, told me in a deep Scots brogue, while we were both living at Kingsley Hall. “ You know Joe, the difference between a neurotic and a schizophrenic? A neurotic bothers maybe 20 people. But a schizophrenic bothers at least 80 people.” (Laing, 1966)

Indeed when it happens, regression may play a big part in such disturbance. That is why when we think of regressive phenomena we tend to relate them to 'mental illness.' Nonetheless, a regression can and does occur during everyday stresses, in response, for example, to deliberate drug induced states, or sensory deprivation, or trauma, or meditation, or new age therapies, or just life itself, such as when we say people are 'stressed out.' Here the phenomenon tends to be reversible and time limited. Moreover it tends to take the socially acceptable form of a few days in bed due to a cold, or a stay at a health spa. The latter is the modern day equivalent of a religious retreat or, in ancient times, incubation at the Temple of Aesculapius. These activities (or non-activities) facilitate self-healing and allow people to reconstitute themselves, and hopefully, function better.

An important aspect of mild, socially acceptable regressions is that they are minimally disturbing to family, friends or carers. Or. there are somewhat more upsetting regressions that occur, and indeed must occur, during the course of the working through of transference relationships in therapy or analysis. In contrast there are momentous dramatizations, regressions which are profound, extensive, disrupt many areas of a persons life, go on for a long time, and are very disturbing to family, friends and carers. These are part of an overwhelming reaction to internal or external events which can be roughly categorized as developmental (adolescence), maturational (marriage) or situational (therapy). They demonstrate an infantile level of functioning as well as a potential collapse or disintegration of the self and of social relationships.

How can we approach these occasions? How do we see them? How can we help them? Paradoxically the very means we have developed to overcome these states, psychological treatments such as psychoanalysis, or intensive psychodynamic therapy, often lead to an activation or reactivation of regressive events, particularly while exploring dependency issues. A further question arises. Is it possible to work with or even facilitate a regression before, during or after therapy, or is it an event that is harmful to the self (as well as others) and should be discouraged?

In a recent review of the concept of therapeutic regression Laurence Spurling concludes that “the “concept of therapeutic regression has outlived its usefulness.” (Spurling, 2008) He believes regression impedes therapeutic progress, rather than helps it, especially because it turns the analyst’s attention away from transference issues and can lead to the analyst “to committing serious boundary violations.” The latter point coincides with Freud’s criticism of Ferenczi for his active interventions with regressed patients.

So Spurling’s view is essentially negative about the therapeutic impact of regression. He does however mention the work of Michael Balint and D.W. Winnicott, both of whom thought otherwise. Balint coined the term, ‘the basic fault,’ to denote the structural deficiencies in the personality of certain patients whose development was faulty and false. According to Balint they needed to return to a state of oral dependency in order to experience what he called a ‘new ‘beginning.’ (Balint, 1968)

Winnicott recognized that patients have both a ‘true self’ and a ‘false self.’ The more distorted and twisted a person is, the more he or she inhabits a false front in order to protect him/herself from, neglectful and disturbing relationships. For Winnicott, regression was a necessary process of going back in order to go forward to promote an untwisted and unrejecting self. Good care meant a strong holding relationship in order to promote not just a new beginning, but a new self. (Winnicott, 1954)

Following not long after Balint and Winnicott, R D Laing introduced a new element in understanding the process of regression. He saw it as a voyage from outer to inner, from life to a kind of death, a standstill from mundane time to cosmic time, from post birth to pre-birth, to the cosmic womb. If not interrupted, he believed that the voyage could naturally return from inner to outer, from death to life, from stasis to movement, from an old self to a true self, and from, as Laing put it, a 'cosmic fetalization to an existential rebirth.' (Laing,1967) He also saw that for many people psychological mothering, no matter how kind and how intensive, was not enough. Such a voyage needed a sanctuary, a tangible place, a nurturing environment where people could go through their voyage.

About the same time as Laing was developing his ideas, he was consulted by a forty-two year old nurse, Mary Barnes, who had heard of Laing's work, and was looking for a place where she could 'go down' in order to overcome her own twists and knots. She felt she had to return to a pre birth state before this could happen. Mary became the perfect embodiment of Laing's ideas. I had the privilege of helping her to go through her regression at the Kingsley Hall community which was established by Laing and others in London in 1965. Mary and I told the story of her descent and return in Two Accounts of a Journey Through Madness. (Barnes & Berke, 2002) Eventually Mary became a celebrated writer, painter and mystic and her story gave hope to untold others. So we can say her experience was positive.

Mary was not alone. Laing also wrote about Jesse Watkins, a sculptor and friend of his who also underwent 'A Ten-Day Voyage' which Laing described in The Politics of Experience. (1967) Laing commented, "Can we not see that *this voyage is not what we need to be cured of, but that it is itself a natural way of healing our own appalling sense of alienation called normality?*"

The stressors which lead people to embark on such journeys, or feel the need to deconstruct themselves, include intense unremitting anxiety. Remarkably while Laing was formulating his ideas, Kazimierz Dabrowski, (1902-1980) a Polish psychiatrist, was developing a theory of positive disintegration. Dabrowski believed that psychological tension and anxiety were necessary stimulants for the growth of the personality and the development of the self. He postulated that disintegrative processes, however painful, were essential steps for enhancing and activating human potential, what he called 'Development Potential.' (DP) This occurred through the disintegration of the old self, itself based on alienated instinct and socialization, and its advancement into higher levels of development. He further believed that this process would happen naturally in people with strong DP despite external social or family efforts to prevent it. (Dabrowski, 1964) Although I don't think Laing knew of his work, for I never heard him mention him when I was working with him, many of Dabrowski's ideas carry a curious resonance to those of Laing.

Dabrowski also taught that people with low DP will not undergo disintegration no matter how facilitating the environment. This conclusion also coincides with my observation that some residents were not helped at Kingsley Hall. Their journey was aborted, or maybe never took off. They got stuck and remained stuck and were a constant source of frustration and despair to those who tried to intervene. Their regression did not lead to a freeing of the self. If anything they deteriorated. Therefore, we can also talk of a negative or non-therapeutic regression.

In considering whether the impact of regression is therapeutic or anti-therapeutic, whether it has positive or negative consequences, one has to take into account three factors: they are the person undergoing the regression, 'the regressed,' the regression itself, and the regressive context, that is, the overall physical and personal environment, which may be caring or neglecting. There exists a complex dynamic among all three poles of the regression event. 'The regressed,' or person whom undergoes the

regression, may do so in the hope of emerging stronger and life enhanced, as Laing supposed, and as Mary Barnes exemplified. Here life juices outweigh death impulses. But the opposite may also be true. The regressed person may be mad angry, and use his regression to punish everyone and everything he blames for his condition, as well as thirst for and extract revenge. Balint described these opposites as benign or malignant in his book, Thrills and Regressions (1959). Benign regressions, however difficult they may be, are reparative, and seek positive life changes. Malignant regressions are harmful and harming. They serve to injure and destroy their container, whether parents, friends and therapists or the physical environment.

The third element in the triangle is the regressive context, the environment personal and impersonal, in which the regression takes place. It may be strong or weak, holding or non holding, nurturing or neglectful, harmful or helpful. The implication is that this environment can overcome malign regressive impulses or intensify them.

These three poles of regression carry remarkable similarities to the occurrence of sulking, about which I have written in a book soon to be completed called, Why I Hate You and You Hate Me. (in press) Sulking can be seen as the epitome of passive aggression. It also has three poles, the sulker, the act of sulking and the person against whom the sulking is directed, the sulked. The sulker may be mildly angry and seek redress of grievances by a limited not doing. Or he may feel endlessly aggrieved and by withdrawing from life seek vengeance on life. The target of all this, the sulked, is the focus of envy and jealousy for actually or allegedly withholding food, sex, attention, love, and so forth. Meanwhile the action, sulking, may itself be categorized as benign, self limiting, and minimally harmful, or malignant, endless, unremitting and very destructive to the self and others, that is, to the sulker and the sulked. Examples of malignant sulking include mutism, refusal to talk, catatonia, refusal to move, anorexia, refusal to eat, and a whole variety of other refusals. These actions are interpersonal transactions, which

as part of the process of projective identification, aim to drive the object of sulking, the sulker, to despair.

Regression can serve the same purpose, to lead others to feel enraged, abused and abusive, and suicidal. Winnicott commented on this very point when he described some of the ominous countertransference effects of the regressed patients on the therapist in his paper, "Metapsychological and Clinical Aspects of Regression within the Psycho-Analytical Set-Up." (1954) This is a major problem in creating a facilitating environment.

Laing believed that such an environment would in itself be sufficient to enable a person to go through a regressive episode. Kingsley Hall was established with this view. There were no-one in the formal role of therapist at Kingsley Hall-- just helpers and people in need of help. Some residents however did attend psychotherapy, but in formal settings outside Kingsley Hall. The main interpersonal focus had to do with 'being with' regressed others. For Laing 'being with' was akin to acting as a escort during a LSD session. The individual was encouraged to be attentive, supportive, non intrusive, and non threatening. This form of engagement-non engagement became a model for other communities as I shall soon describe. But generally Kingsley Hall did not function as Laing had hoped. The quality of care was inconsistent and unreliable. And the primary focus often shifted from the residents to other political, social or artistic activities. Basically the place was too exciting to be calming. Moreover, unexamined transference and countertransference currents ran rampant.

Dr Loren Mosher, former chief of the Center for Studies of schizophrenia at the US National Institute of Mental Health, was intrigued by Laing's work. He sought an alternative approach to the psychobiological treatment of schizophrenia which he thought was harmful and ineffective. (Mosher, Hendrix & Fort, 2004) Mosher lived at KH for at least a year and then established a kindred project called Soteria, meaning, salvation, or deliverance, in San Jose, California. This took place in a comfortable house

in a residential neighborhood. Primarily non medical staff were available to sit with, play with, talk to and basically be with residents who were passing through a psychotic breakdown. Formal psychotherapy or analysis was not part of the program. But there was a big emphasis on helping residents to gain a psychological understanding of their altered states. Also there was extensive support for the staff in individual and group meetings to enable them to tolerate psychotic processes. Soteria lasted for over ten years from 1971 - 1983. It's non institutional, non drug orientated program was very successful. ( Bola and Mosher, 2003) Yet it closed down due to a lack of funding and opposition from unsympathetic psychiatric colleagues.

Dr Luc Ciompi is a Swiss psychiatrist who was also influenced by Laing and Mosher's work. Ciompi was the founder of a kindred therapeutic community called 'Soteria Berne,' based on a integrative psycho-socio-biological approach to mental breakdown. His work confirms Mosher's contention that Soteria--like environments can be a successful alternatives to hospital and neuroleptics in intervening in acute psychotic episodes. Indeed Soteria--like projects have now been established in Scandinavia and and other European countries. (Ciompi, 1997)

Other residential projects I would like to mention include Diabasis in San Francisco, and the Philadelphia Association communities in London, Diabasis was established with a Jungian orientation by John Weir Perry. Like Laing, he saw that psychosis can carry with it 'elements of the spontaneous reorganization of the self and can lead to self healing.' Perry commented: "...85% of our clients (all diagnosed as severely schizophrenic) have not only improved with no medication, but most went on growing after leaving us." (Perry, 1989) But Perry died in 1998 and Diabasis also had to close because of a lack of funding.

In 1970 I helped to establish the Arbours Association communities in London. Then in 1973 I founded the Arbours Crisis Centre to provide intensive personal and psychotherapeutic support for people going through a

period of severe emotional turmoil. Our aim was to do so in a much more structured and consistent manner than the communities, which at that time were unorganized, with no formal staff, and often frankly chaotic, more like hippy communes. We started by renting a house in a quiet tree lined area of North London and recruited a young couple who had been living in one of our communities to be the house parents, so to speak. This was their home and they invited others to live with them as guests, to maximize the idea of hospitality and minimize issues of regimentation and stigmatization. This format has continued till this day, although we now own a much larger house. We are now able to accommodate up to six guests while three helpers live there on a full time basis. They are the resident therapists (RT) and are themselves supported by about dozen and a half visiting therapists and students.

The Centre offers a formal transference--based dynamic therapy together with warm consistent and containing relationships with the staff and other guests. Like with Soteria 'being with' is a major component of the Centre's approach. The treatment program is itself divided into three parts. The team, the group and the milieu. The team consists of a resident therapist, a guest, and outside psychotherapist, the team leader (TL), and maybe a student doing a placement, and meets regularly three- four hours per week.

The group consists of all residents, therapists and guests, in the house and meets every weekday. But over the years several groups have evolved in addition to the house. They include non-verbal interventions, art and movement as well as the RTs alone, the RTs with the TLs, and all the therapists and students, and various other combinations of therapists and students. These allow for daily clinical discussion and for emotional and psychological support.

The third level is the milieu. This is perhaps the most important aspect of a guest's stay, his daily interactions with other guests, and 'being with' the RTs and non therapists like Vickie, the elderly house cleaner. Until she retired

recently Vickie was the one person with whom some of the guests could most easily talk. We also think pets are a special component of the treatment milieu. The Centre is one of the few places that guests can bring their pets with them, including dogs, cats, birds, turtles, rodents and stick insects. For decades the house had its own pet dog or cat. For the last few years I have brought my golden retriever, named Teva, with me. Many guests, as they regained their equanimity, have graduated to become honored walkers of Teva.

As you can see, like Soteria, we are a relationship centre for people for people who have been very damaged by neglectful and destructive relationships. There is much more I can add about the complex of the structure of the Centre, but this is covered in the anthology, Beyond Madness: PsychoSocial Interventions in Psychosis (Berke, et.al., 2002).

Before concluding I want to describe two very disturbed and disturbing regressed women, both in their early 30's, who stayed at the Centre. One we helped go through a sort of voyage. But the other didn't do so and thought we had failed her. This person was just beginning a career as a concert pianist. I shall call her Mira. Mira had terrible conflicts with her parents who were acrimoniously divorced. By the time she came to the Centre she stubbornly refused to eat or move for days at a time. This aroused tremendous anxiety on the part of everyone at the Centre, therapists and other guests alike. Would she live or would she die?. But Mira gradually began to open relationships with her RT and TL, so much so that one day I was amazed to come in the front door and see Mira painting the hallway with the other guests. Then summer came about and her, TL, also a woman, went on holiday for six weeks. Mira took to her bed, stopped eating, became desperately dehydrated and developed bed sores in several part of her body. Her RT withdrew and could not stand to be with her. But the other RTs remained in almost constant attendance, gently speaking with her and coaxing her to take liquids, especially during a very hot spell of weather. The whole house was desperate. We could barely think or talk about anyone or

anything else. Eventually her physical condition was so bad that she had to be hospitalized. When this stabilized she decided not to come back to the Centre and returned to mental hospital. In response the house regressed, into an angry, spiteful, blaming furore. From our point of view this was a classic example of a malignant regression. -- designed to punish and wreak vengeance on an ostensibly caring world. You can imagine our astonishment when several months later Mira called to thank us for our help to to say that she had resumed her studies.

The other woman whose name is Tamsin had a long history of grand mal seizures. Many neurological examinations gave no indication as to why these fits occurred. Her doctors believed that they were of psychogenic origin. I thought they were temper tantrums, but Tamsin would have none of this. She said what I said was nonsense. The fits just started one day while he was in her 20's and have been the misery of her life ever since then. In addition Tamsin suffered from sleep walking. Unless the door to the house was locked, she would walk out in the middle of the night, apparently in a trance. We were very concerned about where she might go and who might abduct her.

Like Mira, Tamsin experienced long bouts of extreme regression during which she would not eat or talk. She often felt unable to move her legs and stayed in her room curled up under her blankets like a fetus. When she did come into the kitchen she always carried a dirty brown teddy bear with her. On many occasions she slept under a table in the living room, while the RTs spent the night next to her on the sofa. I could go into much greater detail about Tamsin's retreats, or as I believed, sulking with deadly intent. But these are vividly shown in a film about her stay at the Centre, **The Madness in Me**, which was aired on BBC TV in June 2006 ( One Life series).

The regressive episodes of both Mira and Tamsin were ordinary and extraordinary. A common feature of these interventions was the terrible confusion and chaos, rage and despair they generated in everyone who

came close to them as well as how close they came to death This was ordinary. It has happened time and again with regressed guests at the Centre. Each occasion necessitates a herculean effort on the part of all the therapists to struggle with the painful and very raw emotions that these guests evoke including the wish to withdraw, run away, scream, murder, mangle either the guests or each other. Each of these wishes has to be carefully acknowledged and traced to its transference, counter transference and real life components components. Hopefully in this way we can show our humanity to them and enable them to regain their humanity with us. What was extraordinary was how both women seemed able to reconstitute themselves after a period of severe breakdown. Mira, I have already mentioned. Tamsin, after a long period at the centre, has been able to regain her life as a bright young woman about town. Oh yes, she no longer carries a teddy.

So is the impact of regression positive or negative? It depends on the regressed person, the nature of the regression and the regressive environment, as well as the relationship among them. Is the regressed individual life affirming or is he or she malicious and punitive. Is the regression itself benign and self limiting, or is it malignant and endlessly soul destroying? And finally, and this is a very important if, is the regressive context, and by this I mean both place and people, calm, containing, supportive and nurturing, or is it cold, rejecting, neglectful, inconsistent and vindictive? At the least the accounts of Mira and Tamsin show that a facilitating milieu, replete with people willing to suffer on another's behalf, can overcome regressive interludes replete with malicious and life-threatening intent.

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