

Between the Therapist's Vulnerability and the Client's Vulnerability: Building a Therapeutic Intervention Through the Regressive Regions of the Mind

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INTRODUCTION

How does a therapist come up with a therapeutic intervention? How is the intervention generated within the therapist's mind? These questions lead to the idea we will be exploring in this article. The aim of the article is to describe what takes place in the therapist's mind in order for the intervention to occur.

Psychoanalysts such as Winnicott [13] and Balint [1] have addressed aspects of this question when they tried, each in his own way, to identify which types of psychological structures and developmental stages are inappropriate for interpretive work. This view is based on Freud's [8] premise that the patient's maturation involves a transition from the pleasure principle to the reality principle. Later this premise was conceptualized by theoreticians such as Klein and Bion. Winnicott [13] and Balint [1] accepted the basic premise but said that the intervention it produces should relate to the patient's level of emotional functioning.

In his article *Metapsychological and Clinical Aspects of Regression within the Psychoanalytical Set-Up* [13] Winnicott identifies three patient types: patients who function as whole people but have interpersonal problems—these require the kind of psychoanalytical therapy technique developed by Freud [7]. The second group comprises patients with still-maturing personalities, who Winnicott believes are beginning to recognize object dependency. For clients in this group the therapy techniques involve a blend of skills adapted to their developmental needs. The third group contains people with unformed personalities for whom the journey is the main task and where psychoanalysis should be postponed for the duration.

Like Winnicott, in his book *The Basic Fault*, Balint [1] proposes three levels of the mind: the *oedipal level* containing three people, which is driven by conflict and competition, and is the area Freud [6] addresses in his psychoanalysis. The second level, the "*basic fault*," contains two people—a parent / environment and a child, and is defined by a split created by extreme incompatibility between the child's needs and their care from the environment. The third area is the *area of creation*, where the subject is alone and unable to communicate with the world, and where social hierarchy tries to create something from within herself. Balint believes the "classic" technique, which works quite well for *oedipal level* pathologies is unsuited to treating clients with problems in other areas of the mind whose structure of ego is insufficiently strong to allow them to internalize interpretations and conduct what Freud [7] calls "*working through*". Balint explained that he gradually found that the most useful technique for patients in regression in the basic fault areas or creative regions was to accept their regression for a while without trying to force intervention or interpretation on them.

Bollas [3] took the idea that patients have different regions of psycho-development and extended it with his concept of the “unknown,” which the therapist must endure so that the patient can transfer an object identity from the past to the therapist. In such cases, the therapist permits himself to become an empty vessel ready to accept the patient’s projections. The therapist’s willingness to accept the loss of part of his own identity inside the environment created by the patient enables the patient an opportunity to find himself. Casement [5] calls this process “interactive communication” between the therapist and patient and suggests that in order for the therapist to react optimally for the patient he must access resonances from as wide a spectrum of emotions as possible. Casement also advised the therapist to be open to other people’s “otherness” and be willing to feel any emotion that occurs when he is with the other person. Bollas and Casement stressed that therapists not only need to identify the psycho-developmental region in which the patient operates, but also to understand the qualities which the therapist needs in order to be in the mental regions with the patient.

This article enlarges on the above ideas in an attempt to explain the means by which a therapeutic intervention arises in the therapist’s mental regions and engages the relevant mental regions of the patient.

THE THERAPIST’S MENTAL REGIONS

According to Winnicott and other psychoanalysts everyone has more and less mature regions in their minds. Winnicott [12] believed that the role of the “good enough mother ” is to show the infant progressively the complexities or flaws in life in a manner compatible with his mental and emotional capabilities. Thus, during the early developmental phases the psychological regions that the individual’s functioning involve are less mature and as the person advances developmentally, those regions progressively mature. However, Balint [1] suggests that we all have basic faults or regressive regions where significant gaps were constituted. These derived from disparities in congruity/attunement between our bio-psychological needs and the maternal and psychological care, attention, and warmth we received during the formative stages of our lives. In some people, the region where the basic fault occurs is limited and their developmental experiences, such as shedding the illusion of omnipotence, the loss of the mother as the only significant figure, the loss related to the oedipal situation, etc. are normal. For others, the regions relating to a fundamental split are more considerable.

Although working with regressive regions can be a really useful tool for therapists, we should still bear in mind that there are other areas than regressive areas. Other factors are also important, such as the patient’s innate structural bio-psychological characteristics in which a parental presence might be beneficial. These may encourage the internalization of a parent or close relative, although a teacher or mentor might also be internalized. Similarly, other characteristics of the personality such as empathy develop as a result of the parent’s care, or through transference experiences like watching movies or reading books. The therapist’s awareness of his own non-verbal regressive regions will allow him to listen to the regressive regions generated through interaction with the patient as will be illustrated below.

INTERACTION BETWEEN THE CLIENT'S REGRESSIVE REGIONS AND THOSE OF THE THERAPIST

When new patients enter therapy they often hope that the therapist can provide what Bowlby [4] calls a safe place on which they can lean and from where they can investigate the painful experiences stored within them. According to Bollas [3], to undertake this role the therapist must be willing to take on some degree of madness arising from the patient's life and find a way to analytically explore what is happening inside him as a purely subjective personal experience. Winnicott [11] calls the patient's subjective experience "counter-transference," and says that the identifications and predispositions inherent to the therapist's own personal experiences and development, make one therapist's analytical work qualitatively different from every other.

Bollas maintains that the analyst must find a way to communicate his own inner processes to the patient so that the patient can connect with something he has lost and give himself truly to the process of free association. Bollas, [3]. The therapist's subjective experience from which the communication to the patient derives, establishes an initial connection with his regressive areas and gradually draws them closer on a symbolic level. The following section presents a schematic description of this process and an analysis based on a detailed clinical illustration.

STAGES OF THE THERAPIST-CLIENT ENCOUNTER

Stage 1: First Encounter

The client contacts the therapist and talks about his emotional experience using free association and the therapist allows the way the client narrates the experience to resonate in his mind. When we talk about the way the "client narrates the experience", we mean the different means of expression used by the client. This can include verbal, but also non verbal expressions including body language, facial expression, and tonation. In the therapist's case, when we refer to the "experience resonating within him," we are talking about the parallel process to the one described by Winnicott in his article Primary Maternal Preoccupation [14]. The process which takes place in the earlier stages of the therapeutic encounter when the therapy has not yet been born as something real and the therapist-client dyad has yet to be formed. This stage begins with the client contacting the therapist, the first meeting with the therapist at the clinic door, and continues when the client sits on the couch and narrates the experience in his unique way. It is important to remember that this is a critical stage.

When a therapist meets a patient for the first time he does not know which emotional layer has been damaged or its unique features. Unlike purely medical treatment when a practitioner seeks to determine an optimal medical protocol by deciding which organ is damaged in the case of emotional injury diagnosis must not only determine which region has been damaged but also which unique defense strategy the patient has used to avoid feeling the festering wound inside. Thus the therapist must be prepared to open up all areas of his own symbolic and regressive emotional space in order to receive the patient's experience before trying to diagnose it.

Stage 2: Identifying the Psycho-Geographic Region and Accessing it Within Himself

The therapist needs to be patient and to wait until able to identify which psycho-geographic region of the client have been harmed. Bollas [3] wrote, "I found that the effort to discover where I am, what I am, who I am, how I should function, and in which of the patient's psycho-developmental periods, I was living, took months, if not years. The ability to tolerate and value this necessary uncertainty defines one of our most important clinical duties toward our

patient..." Bollas, [3] Here Bollas refers to counter-transference revelations and stresses the need for therapists not just to identify which psycho-developmental region is involved but to *spend time* there himself. The second stage is thus marked by two elements: identifying the region where the damage occurred and entering that region himself. This stage of identification is critical since identification allows the therapist to decide whether to orient the intervention toward the patient's verbal-oedipal regions, which is actually intervention using the usual tools at his disposal, or to build an intervention oriented towards the non-verbal-regressive regions where the therapist must initially access these regions inside himself.

Stage 3: Constructing a Therapeutic Intervention

The therapist knows at this stage which psycho-geographic layer he is spending time in together with the patient and he can then plan an appropriate intervention. If the therapist finds that the patient's developmental needs are located in a pre-verbal psychological region he must find a way to resonate these issues for the patient. This is essential, since the patient is not capable of thinking about or *dares not* think about these areas when he is alone Winnicott, [13]; Bollas, [3]. This intervention requires the therapist to connect with his own pre-verbal or regressive areas and through reflection on them develop an intervention. In other words, we can compare the therapist and the patient to travelers down an unmarked road. Although the therapist is in the driving seat, this is not a road taken by people who "think" and "speak." To travel this road, therapist and patient must use a primitive road map that employs psycho-biological signs so they can communicate; the patient transmits and the therapist receives using the subjective tools at his disposal in order to draw the treatment map. Like a mother caring for an infant in what Winnicott [15] calls the stage of "Absolute dependence" the therapist knows that the unmarked road is followed by an easier road where there are words and thoughts. You just need to travel the unmarked road in order to find it.

Stage 4: Transition from Pre-Verbal Stage to Verbal Stage

The transition from the non-verbal to the verbal stage is made when the therapist creatively works through thoughts that the patient is unable to think and presents them to the patient for the first time in their new guise. This only happens when the therapist and patient have spent a long time on the not-traveled psychological path, and learn to know each other through the difficult terrain. They approach the edges of the unfamiliar region, then move away, then move closer, then further away. They will only be able to talk about the difficulties of spending time in it and the special tools they need to succeed in it once they have jointly deciphered what the region contains. Together the patient and therapist collect one sign after another and start to name the region that was previously "nameless and formless" Winnicott, [13]. The therapist's creative translation enables the patient to engage in a dialogue with his regressive region, feel the pain it causes, and not flee from it, in the knowing that this time he is not alone in the torture chamber of his mind.

CLINICAL ILLUSTRATION—CLIENT "A"

First encounter with the regions of the client's mind

"A", a single, 33 year-old woman, rings her therapist one afternoon mid-week and explains that her friend, the therapist's student, had told her about her. "A": She said you are the only one who could help me. I have terrible problems. But I am not sure because she said you were short and thin. I don't think therapists who can help have that appearance."

On the one hand Therapist felt this was a compliment from "A" —that she is the only person who can help her. On the other hand, she said that her physical build showed she would not be able to help her. TH' found herself wondering if there could be a link between physical build and the ability to help. But she snapped herself out of it saying: That's nonsense. There is clearly no link. But she realized "A" was saying something more—her focus on her physical appearance led her to an initial feeling experience which she allowed her mind to resonate: "Can i contain "A"'s anxieties even if I am thin. Can I protect her?" I cannot say this to her, certainly not at a stage where we do not know one another. So she say: "You want someone to help you so much and you are afraid that a short thin therapist will find it hard to do so."

A: "But do you think you can help me?"

TH': "I don't know if I can help you, but I promise to try."

They made an appointment for the next day.

"A" enters with a somewhat frozen expression, flashes half a smile and resumes her frozen expression. She stands gazing about the room. After a moment, she removes her bag off her shoulder and places it on the couch in the room. She asks for the bathroom and the therapist point to the door. While she is in the bathroom TH' feels physically awkward and strained sitting waiting for her. She stares at the couch where "A" is meant to sit and wonder if she will feel comfortable. TH' can feel her body and the different surfaces in the room. She connects to a level of experience that Ogden [10] calls "autistic-contiguous." Through a preliminary contact with her regressive areas She begins to encounter "A"'s experience.

"A" comes out of the bathroom, sits on the couch, and in a tumble of words starts talking about a new job she began two days before and her high salary. She sits sipping, or more precisely, she sits passionately nursing from her bottle of water. "TH" resonates the experience of nursing in her mind, the need for nourishment, and could easily have slipped into saying something interpretive about "A"'s anxiety at the start of their relationship or "play" with her only in the verbal space she uses. But the fact that she opened up her mental space to the resonance of the experience as a complete experience allows her to feel that the real story is taking place somewhere far more regressive, somewhere with no words, where she wonders: "Am I protected enough to protect A? Can my inner vessel contain A's projections."

Being in the Regressive Region and Resonating the Feelings it Arouses

Whereas the initial meeting with the client is marked by an attempt to identify the psycho-geographic region that sustained injury, in the second stage, the therapist must be with the client in the identified region. By this stage "TH" was aware that the area where A had been harmed was a regressive region characterized by early psycho-biological sensory experiences; a place where there were no words yet, and she felt it might be especially challenging to be in that place.

A: "It was also hard for me to tell my other therapists what happened to me. One therapist forced it out of me after six months. She said therapy cannot occur if you do not talk. I told her and then I stopped going. Another therapist suggested drawing a genogram of my family and asked me if I had a particularly complex relationship with anyone. We drew a genogram. She said we had made progress. I felt she could not cope with me, I stopped going after two appointments." When TH' let "A"'s experience resonate in the her own mind space she felt "A"

was saying that she experienced relationships as intrusive and where she was not protected. TH' looked at A and said she felt "A" was talking about how people have failed to be with her and protect her. "A" listened and responded: "Can I ask you something?". TH' indicated she could: "A": "Do you wonder what to wear for our appointments?" That surprised "TH". She felt physically uncomfortable. She glanced at her shirt buttons thinking one might be open and from there her eyes dropped to her pants zipper.

A's words flooded the therapist with a feeling that something or someone is trying to penetrate an area private to herself. She felt that this was a regressive unexplored area unfamiliar to the client, and all that was required of her, was to contain the feelings of threat and anxiety associated with this area.

Intervention Through the Resonance

After a long stay in the regressed areas of the patient and resonating the feelings that arise, the therapist was able to proceed to a stage of active intervention. Later on, the client wondered aloud whether the therapist was arranging her hair in preparation for meetings with other clients. The therapist then responded:

TH': "I sense you mean that there is something different about the way you look. Something everyone can see and which you are afraid of them seeing." "A" smiled with embarrassment and said: "I'm driving you crazy. Promise me you won't leave me." The therapist resonated her latest statement to mean "Do you have the strength to take care of me / protect me. Will you be there for me even if I fall apart? TH' "You are asking me if you will be so hard [to tolerate] that I won't be able to handle it and will try to get away?" "A" paused for a moment before answering: "You can see me and that is good and scary at the same time." Later she started to tell her, though without much detail, about an experience she had when her father hurt her.

"A": "I was in the living room and my father came up to me. He asked me to forgive him for the past even though he had wronged me? I said I could never forgive him, and he replied: Then start paying rent for living in my home." TH' resonated the feeling of insult and being trampled, the sense of weakness, desperation, exploitation, and basic lack of trust, when someone is more powerful than you, so she said: "You feel that even now when you try to make a new start people are still hurting you."

Weeping, "A" replied: "Maybe there is no point in therapy."

TH' resonated the feeling of total despair and said: "You feel there is no one in the world who can protect you and who you can rely on."

A: You know I came to you because you are also a child therapist. I thought you would suggest games and you never did."

TH' resonate what she is saying: "I am a deprived child and this is another experience of child deprivation."

The feeling that she is also part of an abusive family enacted her response and suggest to "A" that she use the games in the room. But it seems that the response of the therapist derived from projective identification rather than from resonance and this caused A to become anxious, and she said:

"No no! I want the chair, the usual place."

Later on TH' resonated to herself that "A" wanted her with her in a place which knows that the childhood she was robbed of can never really be restored to her.

Verbally Processing the Regressive Experience

"A"s painful realization about things she could not express verbally brought about a state in which she could substitute the body related enactment with a verbal symbol. This state included revelations of tremendous pain, despair, and guilt. In one meeting "A" recounted that one cold evening in the middle of the week her mother invited her out for coffee. "I was happy to have an opportunity to go out with my mother" she said, and added: "I told her about my work and me about her work and then there was a pause and I said that every time I see my father it sets me back and that I find it very hard. My mother sighed and said she was in a big rush and we would continue the conversation another time. She paid the bill, said goodbye and left." "A" cried. After a while she continued: "I went out into the cold dark night and wept." TH': "Your mother let you down again. She left you at the moment you needed her most." "A" stared at her angrily and shouted: "You too. You are leaving me in the dark as well. You can't be with me where I am." Her reaction took the therapist by surprise. She resonated the feeling of offense and anger and realized her interpretation had not met "A" in the place where she was. It was as though She too had run away from being with her in her deepest mental darkness. After a long lengthy pause TH' said: "My answer left you alone. I was not able to be with you in your desolation, in your painful childhood, in your bleeding. A stranger cannot understand it." "A" responded: "Oh I am bleeding so much. I don't know how to stop it." TH' said: "You are wondering if anyone can ever understand you and meet you in that horrific place." Together, gradually, we were able to think the thoughts that had never been thought. "A" invited TH' to be with her in the torture chamber of her mind and allowed her not to leave her there by herself.

DISCUSSION AND SUMMARY

This article addresses the singular importance of the capacity of the therapist to access and reflect on his regressive layers as a means of encountering the patient's areas of regression and which then enables therapist to formulate an accepted intervention. It argues that the character of the intervention is vital for the transition between the non-verbal, unthought regressive experiences and the verbalized, symbolic thought Freud describe it as moving from the pleasure principle to the reality principle (Freud, [8]).

The article is based on Winnicott and Balint's description of emotional levels of functioning and describes how the therapeutic intervention arises when the therapist resonates into his own regressive regions. Bollas [3] refers to this point in his discussion of therapeutic counter-transference when he argued that the therapist should spend time in the patient's world in order to grasp his developmental stage, but he did not develop it enough to characterize the form that the intervention should take— hence the unique contribution of this article.

The illustration shows that in the encounter with each client the first step is to identify the dominant psycho-geographic area of the person's mind. Intervention is only possible once the client and therapist have spent time together in this area. In order to be in the regressive area the therapist must visit pre-symbolic, pre-game regions foreign to her consciousness. To connect with them she must open a window onto her own regressive areas: areas that are more scarred, less beautiful, less pleasant. A narrow crack can be opened in the window or it can be opened wide and represents the client and therapists' movement from frightening places to less frightening places and back. The therapist and client can only spend as much time as the client can tolerate in those areas. But, the window once opened must stay opened and the client is the one who controls how much it opens and closes. The process described here involves moving backwards and forwards between the four main stages, which are: 1. identifying the region, 2. being in the region, 3. resonance, 4. determining the treatment plan. It is the systematic repetition of these stages over a period of time that allows the client therapist to name previously unthought thoughts, and to process the loss of the past and be born again in the present. Slowly these thoughts can be made more symbolic and only then it may be possible to live with them. For the therapist to be able to resonate within the regressive areas of her own mind she must investigate complex questions. For example, in "A's case, She wondered whether the sight of her small physical frame arouses an experience of a person who has problems taking care of others. In her mind, these thoughts also resonated regarding to her relationship with other clients and her relationship with her own body and her close family. The therapist ability to differentiate between herself and "A", between "A" and other clients, and between the consulting room and her family life were one of the most complex tasks. This article has attempted to demonstrate the complex movement between an uninhibited slide into the profundities of the mind and the need to maintain distinctiveness when this slide occurs. If the therapist succeeds in entering the regressive areas without losing the sense of distinctiveness he will reach insights that can significantly advance the treatment. The article's distinction lies in its focus not only on the intervention but also on the regressive process leading to it. Further research is recommended to examine the application of this process in the group therapy context and for different types of clients.

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