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PRIMAL REPRESSION: CLINICAL AND THEORETICAL ASPECTS

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THE STORY SO FAR

At Madrid we reviewed and revised the theory of repression in the light of nearly half a century of clinical development, and drew attention to the general neglect of Freud's important concept of primal repression (Cohen & Kinston, 1984). We accepted Freud's view that meeting a need leads to mental representation in the form of a wish, and argued that a failure in need mediation would result in a persistent absence of associated wishes (internal self/object relations) and thus a gap in emotional understanding (psychic structure). Such a failure was held to be the essence of trauma and the basis of mental illness; and the resultant absence was primal repression.

While establishing the significance of inner mental life, Freud tended to see neurosis as produced by frustration rather than trauma. However this conceptual equation of frustration and trauma was checked by his observation of wartime traumatic neuroses (Freud, 1920) and in his final major synthesis he reasserted the significance of trauma in psychopathology (Freud, 1940). Modern research leaves us in no doubt that trauma can produce neurosis and other forms of mental illness *de novo* in adult life (Eitinger, 1964; Kardiner, 1941; Simenauer, 1968). However, the trauma paradigm has not been fully developed and generally accepted as the basis for emotional disturbances originating in childhood (Cohen, 1980, 1985). Despite this, many clinically-driven developments seem to be rooted in the conceptual distinction between being frustrated and being traumatized (Freud, 1967; Krystal, 1978). For example, Winnicott (1954, 1960) argued that in the area of 'ego needs', in contrast to 'id wishes', the analyst must adapt to the analysand rather than frustrate him. In this increasingly accepted line of thinking (cf. Appendix), wishes often need to be frustrated and this is not traumatic; but frustration of needs, better termed failure of the environment to meet needs, is to be avoided. Such failure is traumatic and results, metaphorically, in a persistent wound (from Gk. $\tau\rho\alpha\nu\eta\alpha$ = wound) or hole in the psyche.

The hole in the mind is, we believe, what Freud recognized as the mysterious core of mental illness and called 'primal repression'. We identified three methods of self-healing or psychic adaptation once traumatization has occurred. First and most immediately, the hole may be covered up; this is what has been conceptualized as 'object-narcissism' or 'narcissistic organization', a form of self-protection metaphorically described as a shell, facade, armour, cocoon, cover or false self. Second, the hole may be avoided and a greater measure of psychic flexibility attained through symbolic transformation of stimuli associated with the trauma; this is repression proper (ego defence) which is metaphorically described as a barrier, wall or dam. Third, the hole may be repaired with the aid of another person who subsequently mediates the needs not met during traumatization. Hole repair is what psychoanalytic therapy is about.

An important conclusion of the above theory is that all individuals with neuroses and serious character disorders, as well as those with borderline and psychotic conditions, should demonstrate the clinical manifestations of primal repression during full analyses. Similarly, the theory

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implies that the transition from repression proper or object-narcissism to primal repression is of the utmost significance for therapeutic effectiveness. Evidence supporting these hypotheses now exists in abundance in the literature but is not explicitly drawn together or clearly conceptualized. The aim of this paper, therefore, is to develop our theoretical arguments further and to flesh them out with illustrations and evidence from clinical examples of our own and others. In particular, we will clarify the clinical features and difficulties associated with emergence of primal repression and its repair.

PRIMAL REPRESSION

Primal Repression and the Unrepressed Unconscious

Primal repression is a difficult concept, partly because the label has an unsatisfactory and misleading implication that something mental had been or is being actively 'primally repressed'. Frank (1969) described primal repression as 'the unrememberable and the unforgettable' residue of trauma. We concluded that primal repression referred to an absence of psychic structure, that is to say of emotional understanding, where such structure could and should be (Cohen & Kinston, 1984). The absence or loss of structure was brought about by traumatic events which left instead some form of permanent impression on the mind which is not usable or useful. Because the impression is not a representation (in the usual sense of that term), it does not require specific mental activity to keep it from consciousness. However its presence manifests powerfully in a person's relationships and leads to reproduction of the trauma or aspects of it throughout his life.

Because primal repression is a part of the mind where consciousness does not exist, we conjecture that it is in close connexion with the unrepressed unconscious, or to use Matte Blanco's (1975) concept, 'symmetrical mode of being'. The unrepressed unconscious is a type of activity underlying all experience. (This distinguishes it from primal repression or the repressed unconscious which may be thought of as 'regions' of the mind.) Unrepressed unconscious activity is distinct from repression proper which keeps certain wishes and hence conflicts out of conscious awareness. It is precisely because repressed unconscious experiences are *represented* (i.e. are predominantly in 'asymmetric mode' in Matte Blanco's terms) that they can appear in dreams, slips of the tongue, symptoms and so on and can be brought into consciousness by interpretation. By contrast, the (non-represented) trauma that constitutes primal repression cannot be simply observed or experienced by the analysand or brought directly to his attention by interpretive comments.

The re-emergence of the traumatic state in an analysis is conveyed by pre-representational experiential elements including sensory impressions, stereotyped actions, physiological reactions, and isolated images or affects. These often hang loosely together and do not usually lead to a well-formed understanding in the analyst's mind that can be usefully fed back as an interpretation. Such generalized disorganization may or may not be associated with intense anxiety or terror, but it is incompatible with psychic or physical existence if persistent. Although the historical actuality underlying the trauma may not be recoverable in detail during re-emergence of the traumatic state, symbolic links are usually detectable and need to be used in analytic reconstructions.

Example 1: (Dowling, 1982)

Dr Dowling reported a female patient who had two types of repetitive dream linked with childhood trauma. The first type corresponded obviously to emergence of repressed unconscious experience. It consisted of recognizable primal scene content, used visual and auditory imagery, and was constructed by symbolization and primary process operations to form a more or less coherent narrative. The associated anxiety was intense but relieved with awakening. The second type of dream 'consisted of imageless terror and diffuse feelings of abandonment and emptiness'. The terror took several days to recede, during which time the patient drove dangerously, drank excessively and had exacerbations of colitis and neurodermatitis. We suggest that the second type of dream corresponded to primal repression experience and transient emergence of the trauma. Terror and possibly drinking were non-specific aspects of the traumatic state; dangerous driving and colitis were probably symbolically linked to childhood events.

The risks associated with irruption of unre-

pressed unconscious activity in association with primal repression may not be anticipated in well-functioning neurotics in whom serious disorganization seems unlikely. Neurotics are healthier than borderline or psychotic individuals because they have well-developed systems for reliably avoiding their traumatic states. However, if primal repression is approached during the analysis of a neurotic, the potential for death, disintegration or madness, previously absent and unimaginable by both patient and analyst, is sensed as a possibility. Fear due to real danger, rather than anxiety based on fantasy, then enters the consulting room.

We postulate that whenever object-narcissism is challenged and the traumatic face of primal repression activated, death or near-death events like a major illness or serious accident to the patient (or his intimates) become a real risk. These horrific events are characterized by being recognizably meaningful rather than merely coincidental. How avoidable such meaningful catastrophes are, is as yet unknown; but we suspect that the appearance and handling of the dangers inherent in psychoanalytic work may be much affected by the way the analyst *conceptualizes* the psychoanalytic process.

Example 2: (Yorke, 1980)

Dr Yorke described a woman attending a colleague for analysis on account of 'sexual difficulties with her husband which were manifest in a conflictual refusal to make herself sexually attractive to her husband ... she made no concessions to feminine beauty of any kind ... (but) at the same time she showed strong sexual desires (towards) men who were unattainable' (pp. 190–91). Her analyst found that 'these conflicts and their infantile antecedents quickly appeared in the transference and a more or less classical psychoanalytic treatment was soon under way. Unfortunately physical symptoms supervened and a carcinoma of the genital tract was diagnosed which required mutilating surgery' (p. 191). As a result of this, the patient began to dress and groom herself attractively. Despite the meaningful dove-tailing of her psychopathology (sexual refusal), her illness (genital cancer), and the psychosocial consequences of surgery (sexual intercourse became impossible), Dr Yorke does not consider the hypothesis that the cancer and surgery were an integral part of the process in this psychoanalysis.

Most analysts know of analyses with disastrous consequences for the analysand—though the link to analytic work may not be as obvious as in Example 2 above. However theoretical explanations of such results are still weak. For example suicide is psychoanalytically understood in terms of 'intensity': either 'weakness' of the ego or its defences; or 'strength' of masochistic impulses, of revenge towards some pathological introject, or of fantasies of rebirth and so on (Lapinski, 1985). Such theory is unhelpful in clinical practice.

Example 3: (Lapinski, 1985)

Miss J had lost two carers in childhood: her mother died when she was 5, and her grandmother died when she was 12. Her first analysis had ended with overt rejection of the patient by the analyst, which precipitated a serious suicide attempt. Her second analysis at the age of 28 commenced with the analyst feeling shut out and unable to communicate. Various other forms of object-narcissism followed: idealization, deadness, silences; all of which were sensitively handled and interpreted by the analyst. By the second year of the analysis the patient began to speak of her need to have someone to be connected with. And the analyst had brought the two elements of her psyche, the needy fragile dependent self and the invulnerable, cold, self-providing self, out in the open. Miss J finally openly expressed her concern that the analyst might abandon her; and about that time the analyst announced a one week break two months later. This led to dramatic deterioration: the analysand did not attend or talk properly, and 'made nonsense out of everything'. The analyst feared psychosis or suicide and wrote: 'I desperately tried to keep the analysis going ... I found myself becoming more psychotherapeutic at times'. Miss J repeatedly complained about feeling unwell and the analyst finally encouraged her to see a doctor. She did so; was given sleeping tablets; and made a determined suicide attempt. Death was averted only by chance; and she was revived in an intensive care unit. The analysis continued in a negative and destructive way and Miss J stopped coming a year later.

Example 3 illustrates the themes which will recur and be developed in this and later papers:

Activating trauma risks catastrophe. Because the trauma here involved abandonment due to deaths, it was almost a certainty that death or near-death of someone would feature when defences and protective devices had been worked through.

Return of the trauma, expressed as overt deterioration and disorganization, is to be expected when the importance of the analyst is out in the open. Here the patient then believed that a routine break 'made a nonsense out of everything', that is to say made a nonsense out of the idea of her

analyst as the nurturing attentive figure he had at last become for her, and which she so desperately needed.

With emergence of the trauma, action begins to dominate the clinical material. Here the analysand's feelings about the break were expressed in actions, and analytic interpretations became futile. The analyst felt compelled to act, 'found himself' adopting a psychotherapeutic approach, and played an inadvertent part in the near-death event.

Psychoanalytic work will flounder unless the analyst has a clear conception of what is to be expected when primal repression is reached. Then trauma, risk and action—rather than talk, feelings and dreams—become primary features of the analysis. Coherent and explicit guidance on understanding this phase of an analysis is the present challenge.

The Dual Function of Primal Repression

Primal repression, with its close connexion to the unrepressed unconscious, has a dual and paradoxical function. On the one hand it is the site of catastrophic, unthinkable, past-but-ever-present trauma and associated confusion, terror, hopelessness and loss of self-preservative functions; while on the other hand it can serve as that 'frail bud of psychic structure' (Rechhardt, 1983) from which growth occurs.

Emotional growth, in the sense of identity change, is driven in childhood mainly by physical maturation and external, largely uncontrollable social circumstances. However between adolescence and old age, identity change is primarily a matter of personal choice. The adult is repeatedly faced with decisions—marriage, children, work, career changes—which will powerfully define his life experience and alter his possibilities as a person.

We assume that emotional growth in the face of these challenges is a necessary concomitant of healthy living (cf. Erikson, 1950), and that such development depends on contact with the unrepressed unconscious. Each new phase of social life brings with it the task of once again trying to understand one's personal world. New needs and possibilities arise and consequently a new way of being can be chosen. At these times, reality for the individual becomes confusing; his experiences become intense, and somewhat chaotic; he is uncertain how to interpret the world and what to say or do; he feels isolated, self-preoccupied and self-doubting. Such healthy confusion marks the limitations of a person's capacity to understand his world. Given appropriate facilitation by a friend, mentor or parent, it may lead to a new or deeper understanding and a richer sense of self. Such resolution is often rapid and relieving or even exhilarating. In gifted individuals, the process can lead to a new vision of the world and perhaps deserves the label 'creative illness' (Ellenberger, 1970, pp. 447–48).

However people sense the risks involved in choices which demand commitment; and we have observed that psychosocial-driven identity change is often associated with transient physical or mental illness. (The effect of life-events on health has now an extensive empirical, but psychoanalytically-uninformed, literature.) Sometimes a person decides to draw back, perhaps wisely, and attempts to preserve the status quo. To the outside world he may then appear unimaginative, immature, or rigid; or to be denying the need to change. If change is unavoidable, a person may sometimes avoid risk and short-cut confusion by converting to a new ready-made belief system. But, if both choosing and not choosing feel impossible, then permanent illness or death are likely. Such emotional death based on inability to adapt is recognized in animals, even cockroaches, as well as in humans (Carrighar, 1965; Engel, 1971).

Thus normal maturational crises, experience in difficult circumstances and creative thinking show interesting parallels with trauma and its repair. In all these states, the existing psychic structure is incapable of assimilating some new situation and the person is especially dependent on or vulnerable to the environment (cf. Freud, 1920; Kris, 1952; Gill & Brenman, 1959; Rappaport, 1958). The aim or requirement is *metanoia* or personality transformation. Past experience is no longer a guide, and the existing matrix of understanding becomes irrelevant; so increased contact with the unrepressed unconscious is required. Unfortunately, following psychic trauma, primal repression is activated whenever identity change must be handled, and this explains the frequency of illness.

Primal Repression and Other States of Mind

Primal repression is a state of mind in which a variety of whole person phenomena may appear. So far we have emphasized only three of these—the persistence of trauma, the possibility of emotional growth, and the potential for meaningful illness, death or other catastrophe—more will be added as the paper unfolds. Other labels used by psychoanalysts apparently referring to this state of mind do exist: e.g. 'transference neurosis' (Classical school; Kohut, 1984), 'psychotic core' (Kleinian school), 'basic fault' (Balint, 1968), 'non-integration' (Gaddini, 1982a), 'breakdown' (Winnicott, 1974). However none of these labels seems any better than Freud's. All focus unsatisfactorily on one or other aspect of the state of mind; all fail to link clearly with repression proper; and all are now sectarian.

In order to put primal repression in perspective it is necessary to recall that there are other states of mind that emerge in an analysis: neurotic or defensive, object-narcissistic or self-protective, and open or spontaneous. A person in any one of these other states may reveal the existence of primal repression. This phenomenon deserves some scrutiny.

When an individual is open to experience and can face himself, he may become aware of his own primal repression. In such cases, he may refer spontaneously to a 'hole' in his mind, or to 'something missing'; or there may be less direct associations focusing on holes, faults, deficits or defects, with further associations to mending, repairing, or healing.[1] The person has a sense of requiring assistance in understanding or getting a perspective on himself and his situation, but tolerates separation well and misses significant others.

Example 4:

Mr J was a seriously disturbed 30-year-old clerk, who had never left home and had a complex perversion. After 2 years the intense initial terror of analysis reduced, and over a short calm period his associations centred around the black holes in outer space. He responded well to interpretation based on the idea that analysis was helping him discover what he was like: a person unable to relate properly and yet desperately clinging, filled up with badness and identified with his anus. The following weekend came and went, for once, uneventfully.

Example 5:

Mrs Q, a highly successful woman of 40 and married with children, was in her 6th year of analysis and was vividly and terrifyingly re-experiencing past traumatic events which included witnessing maltreatment of her brother, being physically and emotionally abused herself, and being neglected. In a brief pause between states of panicky disorganization she described herself as 'clinging to the inside of a well'. She agreed that her relivings felt as if she had been repeatedly falling into 'that well'—and saw that this was necessary 'to get well'.

The defensive neurotic state of mind most effectively screens out primal repression because it is associated with flexible relating. The existence of primal repression may however be inferred by the way the person sets up relationships on the basis of over-valued and often secret wishes (or defences against these) without a full and automatic appreciation of his own needs and those of the other. By implication, therefore, there is a gap in psychic structure where these needs should have been represented. Neurotic wishes partake of the catastrophe from which they were derived in their urgency and their associated anxiety.

Example 6:

Mr B was a 35-year-old moderately successful married businessman diagnosed as a neurotic. The transference soon reflected this diagnosis. For example, over a long period he repeatedly struggled anxiously and guiltily with irrational urges to get off the couch and rearrange furniture in the consulting room. During the analysis of his neurotic state he made contact with a variety of repressed wishes and conflicts. However he found the idea of actually needing the analyst to value him and care for him alien so he did not miss the analyst during holidays. When he finally made contact with these ordinary human needs, he did anticipate missing the analyst on vacation. On his return he reported having done well but had 'felt a hole'. [He suggested that, previously, missing would have meant endless dependency and an inability to maintain his own identity.]

Object-narcissism (narcissistic organization) is a form of self-protection based on global blocking of self-awareness (self-narcissism) and hence an

[1] The phonological similarity between 'hole' and 'whole' is interesting. When a person is healthy (etymologically from 'whole') he can contemplate the hole (etymologically from kel = cover, conceal). The antithetical etymology of hole suggests that it is a primal word. Also cf. use of 'well' in Example 5.

absence of genuine direct relatedness (Kinston, 1980, 1982, 1983a, b). Primal repression will be more or less easily inferred depending on its presentation. At the difficult extreme the analysand may present with an outright denial of need or disturbance, and even be judged normal. At the other extreme, the analysand's plight is obvious: he is overtly confused, reveals a desperate child-like neediness, and conveys a sense of an inner gulf where a person should be. Compliance and defiance rather than mutual need-fulfilment are then used as the bases for relating.

Before discussing the further clinical manifestations of primal repression, it is necessary to explore the context in which it manifests: namely the analytic relationship and the purpose of a psychoanalysis. This is because the emergence of primal repression from other states in an analysis depends on the patient beginning to recognize the potential of the analyst to help him manage it constructively. The recognition leads to a distinct qualitative shift in the patient-analyst relationship; and to describe it we need to introduce two concepts, *primary object* and *primary relatedness.*

Primary object and primary relatedness

Primary Object

Object relations theory is an intrapsychic theory which had grown out of one-person psychology and has not yet grappled deeply with the interactional nature of human experience and existence. The 'object', perhaps prefaced by 'inner' or 'internal' is an intrapsychic construct. It is usually used to refer to something in the experiential world in some sort of quasi-symmetrical correspondence with something or someone in the external world. The term 'object' has also been used to refer unequivocally to external entities as in 'transitional object' (Winnicott, 1953), or 'autistic object' (Tustin, 1980). Similarly, psychoanalysts, most notably Melanie Klein, have referred to the mother or her breast as the primary or primal object, meaning the *first* external thing to which the infant relates.

The specific *concept* of 'primary object' was formally introduced by Balint (1959) to refer to real world objects which had the characteristics of substances like air. Such an object is taken for granted, cannot be destroyed, is unconcerned about keeping up proper boundaries, makes no demands of its own, and requires no effort to ensure co-operation. The person has no sense of power or control over the primary object, but if harmony with the object is disturbed there is a profound threat to life and violent aggression. He termed the relationship with the primary object, a primary object relationship. Superficially it may seem similar to Kohut's and the Kleinians' 'narcissistic object relationship', but Balint was not thinking of an internalized structure and to avoid misconstrual referred to it as an 'environment-patient' relationship (1968, p. 168). He compared his primary object concept with Anna Freud's 'need-satisfying object', Hartmann's 'average expectable environment', Bion's 'container', Winnicott's 'holding function' or 'facilitating environment', Little's 'basic unit', Khan's 'protective shield', Spitz's 'mediator of the environment' and Mahler's 'extra-uterine matrix'.

We prefer Balint's simple term and appreciate the clarity of his formulations. Our primary object partakes of the qualities of Balint's; but on one point we differ. Balint indicated that 'dependence on the primary object ... may decrease considerably or even disappear altogether'. We propose that need for the primary object remains significant lifelong, even if not always in the forefront of conscious awareness; and believe that the word 'dependence' has associations (for example to regression[2]) which make it unsuitable for describing the relationship of a person to the environment which he supports (even creates) and

[2] The concept of 'regression' is frequently used in the literature in association with mention of the return to a 'primitive object relationship'. Such description refers variously and usually obscurely or confusingly to temporal, formal or topographical changes. We avoid the term regression here and later in the paper because, as Laplanche & Pontalis point out, its evocation is rarely enough to tell us in what manner the analysand is functioning (1973, p. 388). The matter is not clarified by adding qualifiers like 'deep', 'massive', 'profound' or 'intense'; and the importance of the primary object and primary relatedness in everyday adult life is missed. Often all that the patient gives up in a so-called regression is a form of self-deceiving social manners. This move in an analysis is therefore better described as a 'transition' than a 'regression': indeed Winnicott (1954), Bettelheim (1972) and others have indicated that 'progression' might be the preferable term.

which actually (and not in fantasy) supports his life.

The primary object originally includes the uterus-placenta, then childhood environment, and later some amalgam of personal relationships, work, possessions, physical environment, social status and religious or secular faith. The primary object generates possessiveness and embodies hope. Its alteration or loss, in whole or part, is resisted strenuously and may lead to illness and death. Hence the high morbidity and mortality following retirement, moves from private domicile into an old people's home, death of a spouse, and generally in life situations when hope is lost (Richter, 1959).

More esoteric but perhaps clearer examples of death following alteration of the primary object and concomitant loss of hope are probably to be seen in deaths after family cursing (Mathis, 1964; Raybin, 1979), voodoo deaths (Cannon, 1942), hex deaths (Collomb, 1976; Milton, 1973), nightmare deaths (Tobin & Friedman, 1983; Freeman, 1967), deaths of deliberately terrorised children (De Mause, 1974) as well as self-willed deaths, dying at pre-ordained times, deaths by suicide, violence, illness and substance abuse following tribal relocations and other otherwise unexplained deaths (Bettelheim, 1943; Weisman & Hackett, 1961; Saul, 1966; Coolidge, 1969; Fisher & Dlin, 1971; Devereux, 1980). The common feature of these cases is the withdrawal of emotional support and confirmation by the significant interpersonal environment of family, friends and/or the cultural community.

We described earlier the use of object-narcissistic protective devices and neurotic defences to avoid the emergence of life-threatening trauma. In the light of this section we can now add that these mental mechanisms themselves become part of the primary object, the personal environment resistant to change within which the traumatized individual lives. The analyst can and must become part of the analysand's primary object. However for growth to occur, the analyst must make direct contact with the patient in a state of primal repression. This seems to be possible only in the presence of a specialized form of relationship, which we call primary relatedness.

Primary Relatedness

Primary relatedness is the term we will use for the direct valuing, nurturing, confiding and reflecting relationship with others, which each person absolutely and objectively needs. It is characterized by intense mutual attachment and deep empathic communication. Such object-relatedness is like the primary object relation in that it is an environmental complement to the individual and so cannot be internalized. When no active form of primary relatedness exists, then the individual lives in a state of psychic death with the primary object—work, possessions, acquaintances, faith, self-supporting fantasies, and so on—covering primal repression object-narcissistically.

What occurs during psychoanalysis, we believe, is first the activation and recognition of the analyst as primary object; and then interpretive work by the analyst to develop primary relatedness. When the state of primary relatedness is developed during an analysis, the person feels intensely needy, vulnerable and sensitive, and experiences hope and risk. The analysand reports intense yearnings for the analyst and pain at separation: Gaddini (1982a) described this as 'the objective need of the other whoever that is (which) remains constant and unavoidable'. Primary relatedness is the root of asymmetry in the psychoanalytic relationship and the prerequisite for repair of primal repression and creation of a new fit with a new personal environment.

Freud contended that 'the first aim of the treatment (is) to *attach* (the patient) to it and to the person of the doctor'. And he explained: 'To ensure this nothing need be done but to give him time. If one *exhibits serious interest* in him, carefully clears away the resistances that crop up at the beginning and avoids making certain mistakes, he will of himself form such an attachment ... (Freud, 1913, p. 139, our italics). For Freud this attachment and the associated rapport with the patient was part of the mysterious phenomenon he labelled transference and he specifically assigned the analyst responsibility for activating it. Freud's views appear to have been submerged by recent concepts like working alliance and treatment alliance which focus on the patient's non-neurotic wishes to co-operate, his

reasonableness and his social contract with the analyst (Sandler et al, 1973, Ch. 3).

Primary relatedness, that is to say deep attachment *in response to genuine interest and help* as described by Freud, though officially minimized, is intuitively appreciated and deliberately fostered by psychoanalysts. Hoffer (1956) described such activity as the 'analyst's transference (which) refers to the human appreciation and responses to the patient's realistic needs in the various stages of psychoanalytic treatment'. It is likely that people have an inherent disposition to respond to such handling and even an inbuilt awareness that a relationship of this sort is necessary if emotional growth is to occur. By displaying interest and attention, by valuing the patient as a person, and by translating recognition of needs into useful actions (e.g. timing of comments, altering tone of voice, ensuring regular sessions, adjusting practical arrangements and so on), the analyst permits the analysand to use him as a primary object.

However the next move to primary relatedness and emotional growth is usually not so easy except in healthy analysands. In most analysands, the move is blocked by the habitual defensive or self-protective reactions to the underlying traumatic state. Overcoming such blocks and moving to primary relatedness may be gradual or dramatic. Winnicott referred to the process of transition as activation of the potentialities inherent in the True Self (1960). Balint (1968) coined the phrase 'new beginning'. Kinston (1983b) discovered a typical pattern, the *positive therapeutic reaction*, in which object-narcissism gives way following conscious activation of self-narcissism (as a negatively-valued self-image) to intense accusations and hostility directed at the analyst for his failures. However, the clinical characteristics of transition to primary relatedness and structural repair of primal repression require more detailed exposition, and it is to this task that we now turn.

Repair of primal repression

We have argued that activation of primal repression can lead either to illness and death or to creativity and emotional growth. The former is the danger that psychoanalysis releases whilst in pursuit of the latter. Physical illness and death may be blocked by production of object-narcissistic states, but at the cost of emotional stagnation or mental illness. Because primal repression only leads to growth when covered by primary relatedness, moving from mental illness to emotional growth is dependent on the replacement of an object-narcissistic relationship by primary relatedness. This is the transition which occurs during successful analyses. In other words, our inquiry has led to the conclusion that *the therapeutic action of psychoanalysis can best be understood as the exposure or activation of primal repression and the transformation of trauma into psychic structure in a context of primary relatedness.*

Before embarking on a detailed examination of psychoanalytic process, we must emphasize that our approach throughout is empirical, and our aim is primarily descriptive. Theory has been introduced only so that we may talk about aspects of clinical reality which are usually taken for granted. In what follows we formulate a normative process with which many, perhaps most, analysts are familiar, but which has not yet been legitimized. Because of the lack of explicit formulations of the processes of psychic growth in terms widely acceptable to analysts, the clinical literature in this area is sectarian and often apologetic, uncertain, or even surprised. Numerous case reports in recent years reveal analysts finding themselves in what they believe to be over-intimate, special-case, or excessively pathological clinical situations which justify the use of heroic, or overly active or permissive interventions (cf. Appendix). Our view is that such individual creative work, apparently over-riding the rules and norms of psychoanalysis, will be benefited and encouraged by a theory which enables them to take their place as a new norm. (Something like this happened when countertransference was legitimized in the 1950's.) We suggest that the clinical situations referred to above, however strange, can be coherently and understandably described using the conceptual scheme of primal repression; and the analyst's responses will then be seen to be requisite rather than improper or irregular.

Three overlapping phases can be distinguished during the repair of primal repression. The first concerns the transformation of neurotic conflicts and object-narcissistic armour into awareness of deficit and need. The second is the explicit awareness and assertion of primary relatedness with

the analyst. The third is the re-emergence and working through of unmet needs and traumatic states so as to establish new understanding. In this paper we wish merely to highlight clinical features, leaving more detailed examination of process and technical handling to a later time. It should be noted that the phases may emerge without the psychoanalyst being aware of them as such—indeed, as in Example 9 below, theoretical pre-conceptions may make such awareness most unlikely.

Phase 1: Establishing Awareness of Need

If patient and analyst are to work collaboratively on repairing the gap in understanding caused by traumatization, then an awareness of this gap must develop. As we have repeatedly indicated, this proceeds via removal of defences and protective devices according to standard psychoanalytic technique. Neurotic defences are less globally effective against the activation of primal repression and so give way to object-narcissism as primal repression is approached. The overt relatedness of more disturbed patients is primarily object-narcissistic, being false or compliant, stylised and distant, or interactive but rigid and out of touch.

Although such non- or pseudo-relating, whether persistent or transient, serves deliberately to prevent primary relatedness developing, at the same time these self-protective devices do form a frail bud of a relationship. However unreal, riddled with contempt or idealization, dishonest or bland, object-narcissistic devices are the only available means that the patient has to engage with the analyst, communicate the uncommunicable, and survive. They therefore serve the receptive analyst as opportunities for direct empathic intervention. Depending on his style and theoretical framework, the analyst may be more or less accepting or confronting, more or less focused on patient-analyst interactions as if they were instinctually driven, and more or less concerned to reconstruct past events.

Our own tendency is to recognize the disconnexion in the transference, relate it to an inner disconnexion from experiences, and then offer links to traumatic childhood disconnexions and gaps in understanding. Whatever the approach, the analyst takes the opportunities provided to appreciate the analysand's object-narcissism and use it constructively. This psychotherapeutic work by the analyst leads to the analysand developing feelings of safety, self-respect and a *sense of deficiency* which slowly replace the sense of danger, negative self-feelings and irrational conflicts or actions which typically predominate at the beginning of analyses.

Example 7:

Mr M, a single highly successful corporate executive in his early 30's, sought treatment when he came to realize the strength of his compulsion to conquer women sexually and then run from them. After 18 months in analysis he could see himself doing a similar thing repeatedly with the analyst. After a variety of neurotic and narcissistic anxieties had been interpreted—mainly shame about weakness, risks of over-dependence and worries about homosexuality—he developed the idea that a more basic reason for his compulsive withdrawal existed. He thought that he and the analyst might discover that at the deepest level he was 'a void' just as much of his childhood had been 'devoid of overt affection'. He expected the analyst to reject this idea out of hand as self-indulgent and illogical; or to interpret it as a defence. However the serious acceptance of his recognition of an absence where a person should be led to a rapid change in his perceptions and feelings about it.

A void = avoid = object-narcissism = presenting symptom

became

the void = specific deficit = de void (negro slang) = aspect of his trauma.

The deficit could be understood and firmly located in his mind and in the past; the present became meaningful; and Mr M began to believe that, with the aid of the analyst, the future might be different.

Analysands, as illustrated above by Mr M, become increasingly aware that the increase in safety, self-respect and hope is directly linked to the efforts of the psychoanalyst. As the analyst becomes a primary object for the analysand, the feeling of hope increases that unmet needs and uncontrollable experiences can be managed in and through the analytic relationship. As this awareness develops, perhaps unknown to the analyst, the analysand moves into the next phase, an assertion of primary relatedness.

Phase 2: Establishing Primary Relatedness

An intuitive understanding of primary relatedness by the analyst often has little effect in the early stages of an analysis. At a certain point, however, the analysand in an open state of mind may become consciously aware of primary relatedness and the risk or implications of becoming attached in this way to the psychoanalyst. He may reflect with apprehension and dismay that 'everything up to now has been all wrong', or realize that 'I have to start my life again with you', or may have dreams of adoption by or marriage to the analyst. This was noted long ago: 'I can only cure such people' said Balint in 1937, 'as, in the course of the analytic work, can acquire the ability to attempt to begin to love anew'.

Example 8:

Miss J, 38 years old, unmarried Director of a Refugee Agency, came with over-involvement in work and an inability to sustain an intimate relationship. In the early years of the analysis, her functioning was mainly neurotic with occasional episodes of stereotyped self-destructive interaction. When issues about herself as a whole person emerged in the form of experiences like feelings of being rejected and difficulties in being herself in the presence of others, then a sense of excitement mixed with dread and resentment appeared in the transference. Excitement because the analysis now seemed to be opening up new possibilities of living for her, based on her conviction that the analyst was committed to her and valued her (i.e. that primary relatedness was established and available for use): dread and resentment because it seemed that analysis would become endless and totally absorbing (i.e. that protective object-narcissistic reactions would intensify). Miss J now started agitating to end the analysis rather than became the agent of the analyst's grand *design*, as she put it. This state was recognized as a positive therapeutic reaction and, predictably, responded to analytic reconstruction of her having to fit into parental designs for her. She abandoned her intention to quit and became more committed to analytic work.

It is not surprising or unreasonable that trust and commitment in damaged individuals builds slowly, secretly and only on the basis of much testing out. In this phase, we have emphasized the turning point when primary relatedness is explicitly and mutually acknowledged. One of the clearest signs is when the analysand openly misses the analyst over the weekend or during the holiday period (cf. Example 6): often it takes years till this occurs.

Presumably the above descriptions, based on analyses where primal repression and primary relatedness is expected or naturally responded to by the analyst, may not apply to analyses where the analyst regards such a role as one to be avoided, minimized or denied. For example a common sign of proximity to primal repression is physical or psychological deterioration. This is because the traumatic state is one characterized by mental and physical disorganization. When understood correctly as a re-emergence of trauma from primal repression, severe deterioration may present an opportunity for the patient and analyst mutually and explicitly to acknowledge the existence and significance of primary relatedness (cf. Example 10).

It could be imagined, however, that in some cases the analysand may need to produce inexorable and frightening deterioration to get the analyst to participate in primary relatedness. In such situations, the analyst is forced to notice that his interpretive work is of no avail and feels helplessly drawn into dealing with the deterioration. Two choices starkly present: the analysis is judged to be unworkable by the patient or the analyst, and termination is sought; or the analyst acts. In the latter case, the analyst senses, despite himself, that it would be appropriate if he were to adapt and offer some form of 'direct care'. The direct care typically described in the literature involves actively valuing and accepting the analysand, recognizing and reflecting his experiences, and being intensely attentive and concerned even occasionally to the point of action on behalf of the patient—in other words finally allowing primary relatedness to manifest.

Paradoxically, the analyst must both adapt in this fashion and simultaneously admit or interpret failure. This is to minimize idealization by the patient and to recognize the analysand's sense of entitlement that such traumatization should never have been allowed to happen or even to re-occur. If primary relatedness is successfully negotiated, then the analysand emerges in a whole person way (often with an image himself as a child), concerned about his life rather than his symptoms. The following case illustrates most of these points (cf. also Example 13). It met the criteria for a positive therapeutic reaction although it was presented as a case of negative therapeutic reaction.

Example 9: (Levy, 1982)

Miss Z, in her early 30's, had suffered from depression and withdrawal from a permanent intimate relationship with a man. Dr Levy described conventional analytic work on the assumption of neurotic functioning. However in the beginning of the third year when it was beginning to look as if improvement might be possible, the patient started expressing disinterest in the analysis and finally declared her intention to stop. She refused to co-operate in analysing this and claimed that 'she would not abide by (the analyst's) rules any longer'. The analyst nevertheless persisted with conventional interpretations of conflict-impulse-defence patterns and the patient's symptoms returned and progressively worsened. 'The gap between us was widening' noted Dr Levy, who became anxious at the deterioration and began fantasying the appearance of psychosis. 'Her anguish and suffering became intolerable to me. Then I decided to change my standard analytic approach'. Dr Levy started paying attention to the patient's actual experience, clarifying it and feeding it back to her, and accepting the decision to terminate. She slowly recovered over two months and then continued in prolonged silence until a week prior to termination at which point she said she wished to proceed with the analysis and presented a dream for exploration. 'I gave birth to a baby with a heart defect. A doctor performed a heart transplant and the baby was alright'; she then cried. The next session she spoke of her hatred for her mother. A second dream was reported and this, said the patient, also captured 'the story of my life'. Dr Levy's comments conclude with 'for the next three and a half years of the analysis, I continued with the standard interpretive approach'.

Phase 3: Establishing New Psychic Structure

The conjunction of being in a needy state and explicit primary relatedness results in the re-emergence of traumatic scenes in the transference and the opportunity to confront past events and unmet needs directly. Again positive therapeutic change may be confused with deterioration by patient or analyst as the patient may present with the inhibition of executive action characteristic of trauma, or with mental disorganization, or a vivid re-enactment of some aspect of the traumatic events. In all cases, however, the management of the reliving by both patient and analyst now generates deep understanding. Both patient and analyst become aware of unexpected and unpredicted major shifts in attitudes, development in real life relationships, and growth of emotional awareness. We will once again be leaving the technical details of analytic working in this phase to another occasion, but the mental process of repair requires some description.

As conceptualized in this paper, the process of repair involves having certain experiences *for the first time*. The analysand is now ready to develop a deep understanding of the events which have affected him, of the historical continuity of his life, of his basic needs as a human being, and of the constraints and possibilities for him in the future. Put technically, the absence of representation that characterized primal repression, must now be converted to wish-based psychic structure. During this process, the analyst's presence and activity serve as a scaffolding on which the patient may construct the necessary new understandings. Pre-stages of representation are frequently in evidence and must be recognized by the analyst as the way the mind grows; and not mistaken as evidence of pathology (which might be their significance in an earlier phase of the analysis). These pre-stages might best be described as primitive forms of symbolization, and they include bodily communication, symbolic equations, use of words as things rather than abstractions, isolated delusional or hallucinatory experiences and frank paranoid (transference) psychosis.

Example 10: Bodily Communication (Cohen, 1981)

Mrs F, a 43-year-old married woman, sought psychotherapy to help her handle situational difficulties with her divorce. Indications of a brutalized childhood emerged and the possibility of analysis was raised. Primary relatedness developed as evidenced by occasional intense yearnings for the analyst after a session. When therapy was complete and a decision about psychoanalysis had to be made, Mrs F appeared at her session looking very ill. She felt mentally disorganized and had been unable to do anything that day except come for her session. She had woken with a severe headache and vomited several times, and would have accepted referral for medical help and abandonment of the idea of analysis. However in view of the generalized disorganization, the analyst treated the headache as a bodily communication and invited her to explore the possibility that she was reliving a past traumatic experience. She then reported a dream: *She was in a horse stall and was told to allow herself to be kicked by the horse. The horse kicked her in the head.* This was then easily connected to past physical and sexual abuse from her father and linked to the transference. She felt and could understand that reliving and reworking the past was necessary for her.

Example 11: Mild Psychosis with Equation of Absence and Loss

Mr A, 49 years, was married and a successful executive who had a sudden onset of homosexual preoccupations, depression and anxiety following appropriate pressure from his manager to go for promotion. The trauma uncovered was the loss of his father at the age of 8, which he had never given much significance. When its seriousness for him could be pointed out and linked to reactions to his manager and the analyst, Mr A began experiencing intense loneliness and painful longings for the analyst alternating with attempts either to control or escape from him. He felt he was going mad, and during a few days' absence of the analyst became extremely fearful that he would never return. This experience led him to develop a deep understanding of what his father's death had meant to him.

Example 12: Isolated Delusion

Mr C had come to treatment as a student with diffuse anxiety and schizoid withdrawal from relationships. Well into treatment, he reported that after leaving a session he suddenly realized that he had body-lice. He consulted his family doctor who reassured him otherwise; but he had taken a medicated bath before the next session and still believed he was infested. It was suggested to him that he was 'crawling with hostility' in relation to a misunderstanding in the previous session and this led to a confirmatory outburst of complaints and accusations. The whole episode could then be explained to him in terms of his childhood experience of being persistently misunderstood or even deliberately confused (i.e. the trauma). He then recollected his unexpressed and almost unbearable hatred of his parents. By the end of the session, the idea of lice was gone never to return—it had been replaced by a small piece of understanding.

A precursor of understanding that requires special mention is action. In the absence of representation a person is forced to express his needs and inner states through action and through provoking the environment, including the analyst, to act. We term this special type of self-transformative action in relation to symbolization *developmental acting out*. Developmental acting out differs from acting out which is defensive, impulsive or gratifying (Sandler et al., 1973, Ch. 9). It refers to action which, by virtue of the absence of wishes, is the only means available for achieving some perspective and awareness of certain needs and experiences, or for affirming identity and mature separateness (cf. Gaddini, 1982b). Lipin (1963) termed the sub-group of such enactments which were modern day reproductions of past traumatic events, 'replicas'. Replica production may lead to reconstruction or interpretation, but its facilitation and handling is non-interpretive.

During developmental acting out, the patient may consciously experience a struggle with intense neediness, psychic pain, a sense of fragility, or anxiety about loss of boundaries. Rather than interpret, the analyst may need to co-operate with requests or explain failure to co-operate in ways that would not be appropriate in other stages of the analysis. Sometimes it is the analyst who struggles and in the end initiates action, hoping that the patient will respond.

Example 13: (Rosenfeld, 1978)

Dr Rosenfeld's male analysand had suffered in childhood but presented with a warm personality. After two and a half years the patient became increasingly hostile and critical. His accusations against the analyst, his comments, attitudes and non-verbal behaviour, all became more and more violent and irrational until the clinical picture deserved the label of 'transference psychosis'. The analysand was judged unamenable to analytic interpretation and an impasse was reached. Finally the man decided to quit after two more weeks. Dr Rosenfeld then asked him to sit up, and encouraged him to go over all his criticisms and grudges. The patient remained critical and sullen but did so. 'During these exploratory sessions' (Dr Rosenfeld writes) 'I did not give any interpretations and adopted an entirely receptive, empathic, listening attitude to him. I also examined, as much as possible, my countertransference, for he constantly complained of some tension in me which disturbed him.' On the last day before he was due to leave, the patient decided to stay in treatment, and warmth once again supplanted sullenness.

Our theory sees such vignettes as reflecting a natural analytic process. We presume that the analytic situation was being used by this patient to replicate a traumatic situation. In his search for understanding, the patient allowed the symbolic level of his communication to become increasingly primitive, first irrational, then psychotic, and then action-based. Death of the analysis threatened and the patient risked rejection and repeat traumatization. Fortunately the analyst acted to establish primary relatedness unequivocally and to give the patient the reparative interpersonal experience which he objectively needed.

Intuition or theory

Theory should be a vital and useful framework

for the practice of psychoanalysis, providing a comforting background of understanding which meshes with the immediacy of intuitive response in the clinical situation. A useful theory will tell the psychoanalyst what to expect during treatment and will influence his technique. Without relevant theory, the analyst's anxiety and uncertainty rapidly increase, leading either to defensiveness and rigidity or to spontaneous and creative rule-breaking. The latter course is gratifyingly frequent. Our final example is of another creative analyst taking a patient through what we trust the reader now recognizes as the standard clinical pattern of a positive therapeutic reaction (PTR) followed by the typical deterioration and emergence of primitive forms of symbolization intrinsic to primal repression repair.

Example 14: Kohut (1984; pp. 178–183)

A professional man in his late forties had had a number of previous unsuccessful therapies. He decided to try again with Dr Kohut after hearing him speak and being affected by his humane, simple and direct attitude (*early onset of explicit primary relatedness*). The analysis initially proceeded in an atmosphere of co-operation though the patient suffered from headaches before the sessions, and repeatedly complained about his previous therapists and parents for their poor handling of him. Then, after about a year, he started filling hour after hour with detailed accounts of his headaches to little apparent purpose and with no response to conventional interpretations (*PTR Phase 1: persistent object-narcissism*). Dr Kohut then suggested to his patient that 'paradoxically, the worsening of [his] condition was part and parcel of his improvement ... [and] ... as a ... consequence ... he felt continuously traumatized and overburdened' (*PTR Phase 2: activation of a negatively valued self-image*). After a brief favourable response, the patient 'began ... to accuse [the analyst] of lacking all under standing and of ruining him' (*PTR Phase 3: release of direct object-related accusations and hostility*). The patient's 'psychic condition worsened alarmingly' (*emergence of traumatic state*) and he became increasingly paranoid (*appearance of primitive forms of symbolization*). At the peak, writes Dr Kohut honestly 'I simply asked myself whether it would not be better to stop the treatment and send the patient to someone else to cool off' (*rejection and abandonment of the patient and repetition of childhood trauma*). In this period, the patient 'not only harbored suspicious thoughts and told me about them but proceeded to act on his conjectures' by taking his television set to a repair shop to check that it had not been tampered with to make it sound shrill and harsh (*developmental acting out whose symbolic meaning is unclear to an outsider*). The analyst accepted the reproaches, and specific material appeared relating to the father's failure to foster the analysand's male development (*recovery of part of a small childhood trauma*).

As far as can be judged, the psychoanalyst was quite unaware of the typical nature of the whole process. His urge to abandon the patient was apparently handled by sheer guts rather than by recognizing it as a product of the patient's past experience (i.e. as countertransference). Indeed from a theoretical perspective, Dr Kohut suggests that nothing much need be said about this most difficult and crucial phase of an analysis but that 'the transference [is] clicking into place' (p. 178). He refers to his own theories as helping him but by this seems only to mean that the analyst must 'open-mindedly and non-defensively ... resonate empathically with what the patient is experiencing' (p. 182). His own theories of transference and narcissism as summarized at the end of the vignette (p. 183) appear irrelevant and unhelpful in relation to the detailed analytic work required. His prime plea seems to be for the 'analyst's continuing sincere acceptance of the patient's [experiences] as (psychologically) realistic' (p. 182).

Managing the transference through intuitive empathic responsiveness set in a framework of genuine acceptance *is not a practical precept but an ideal of psychoanalytic working* which few would dispute. The practical question is how analysts may be assisted in pursuing this ideal. Dr Kohut's rebuke to analysts who find this task too difficult—who 'cannot stand the heat' of the full-blown transference (p. 183)—is perhaps unfair. If a psychoanalyst knows what to expect, then by and large he will be able to manage the difficulties inherent in reaching the area of trauma and primal repression. Neither exhortations to be sincere or empathic, nor highly abstract theories, nor simplistic slogans (like 'interpret the transference') are a sufficient guide. What the analyst needs, if he is to stand the heat, are straightforward descriptions of what he is likely to encounter and some explanations which help him make sense of these accounts. We have attempted to provide such guidance by categorizing the relevant phenomena and providing the necessary concepts and mid-range theory.

Conclusion

This paper has focused on the clinical presentation of primal repression and has only briefly touched on its clinical management. Theory has been introduced, but only as required to simplify explanation and description. We have found that Freud's fundamental early notion of primal repression, when elaborated in the light of modern clinical and theoretical developments, becomes a central and fruitful concept. Many psychoanalytic thinkers have compensated for their neglect of primal repression by re-discovering or re-conceptualizing some of its component phenomena, while neglecting or ignoring other components. Case illustrations in the body of the paper and the Appendix suggest that when these ignored phenomena occur in the course of an analysis, they may be dealt with intuitively or taken for granted. However such intuition, spontaneity and creativity gain a valuable ally when supported by a usable theory like the one offered.

Without the theory of primal repression, it seems that the practising analyst will be surprised and frightened by the re-emergence of traumatic states, will mistake therapeutic progress presenting as deterioration for therapeutic failure, and may increase the likelihood of a meaningful catastrophe. The dangers inherent in psychoanalysis have not received the necessary attention in the literature, probably because of the absence of a clear theoretical framework which predicts them. It is proposed here that the root of catastrophe lies in the persistence of trauma and the influence of the unrepressed unconscious activated in the context of a therapeutic relationship.

The ideas in the paper also begin to contribute to resolving the controversial and somewhat unreal polarity that surrounds the impact of external events on mental life—that they determine or that they are irrelevant. While it is impossible to recover the exact details of past events, ongoing work to obtain an objective perspective on significant painful and destructive experiences is seen as a component of healthy development. Such work is usually difficult at the commencement of analyses because past events are either denied, devalued or used as an opportunity to avoid responsibility and to feed self-defeating gratification. The process of reconstructing the past once these habits of the mind have been dealt with requires further examination.

Another area which requires investigation is the process whereby object-narcissistic and neurotic states of mind are developed and abandoned. We have explained that traumatic events and the repair of primal repression are typically not approachable until many months or many years of analytic work on these states. Therefore much is understood about their phenomenology and technical requirements. However less is known about the conditions for transition to primary relatedness, about vicissitudes of this transition, and about working within established primary relatedness. The basic message that emotional growth is the repair of primal repression in the context of primary relatedness only takes us so far; and is easier said than done. In a coming paper, we will endeavour to focus in more detail on the patterning of psychoanalytic work as emotional growth is deliberately pursued.

The paper also reveals gaps in our understanding of such fundamentals as trauma, action, needs, and the unconscious. If these could be better formulated, then together with the propositions in this paper, it may be possible to move beyond the consulting room and offer a deeper practical understanding of matters like parenting, life-events, physical illness and social disturbance.

Summary

Primal repression, long an obscure and unusable concept, has been given a precise place in a recent re-working of the theory of repression (Cohen & Kinston, 1984); and this paper specifically examines its properties and presentation. Primal repression refers to an absence of psychic structure which can be made good in the process of emotional growth. It is a part of the mind where trauma persists; and it has a close connexion to the unrepressed unconscious. Direct emergence of primal repression is a threat to life and its activation is therefore risky. During psychoanaly-

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sis, primal repression is normally avoided by object-narcissism buttressed by neurotic defences, but it may be reached and worked with in the presence of a non-internalizable valuing and nurturing relationship which we label 'primary relatedness'. This relation is therefore the interactional context for emotional growth. Numerous clinical examples are provided to demonstrate characteristic features of this region of the mind as seen in psychoanalyses. Vignettes illustrate the experiences of patient and analyst as primary relatedness is established; the consequent re-emergence of traumatic states and unmet needs, often initially in the form of severe physical and psychological deterioration; primitive forms of symbolization in the course of repairing primal repression; and the role of action in emotional growth.

Translations of Summary

Le refoulement primaire, concept longtemps obscur et inutilisable, s'est vu attribuer une place précise dans une récente re-élaboration de la théorie du refoulement (Cohen et Kinston, 1984); cet article se propose d'en examiner les propriétés et la survenue. Le refoulement primaire renvoie à une absence de structure psychique qui peut être compensée au cours du développement affectif. C'est une partie de l'âme où le traumatisme persiste; il est en liaison étroite avec l'inconscient non refoulé. L'émergence directe du refoulement primaire constitue une menace pour la vie et son activation comporte donc des risques. Au cours d'une psychanalyse, le refoulement primaire est normalement évité par le narcissisme objectal étayé sur des défenses névrotiques, mais il peut être atteint et élaboré lorsqu'existe une relation valorisante et enrichissante non-internalisable que nous appelons 'état relationnel primaire'. Cette relation constitue donc le contexte interactionnel pour un développement affectif. Cet article fournit de nombreux exemples cliniques pour démontrer les traits caractéristiques de cette région de l'âme tels qu'ils apparaissent au cours de psychanalyses. Des vignettes illustrent les expériences vécues du patient et de l'analyste lorsque s'établit cet état relationnel primaire, et elles montrent la re-émergence d'états traumatiques et de besoins non satisfaits qui prennent souvent au début la forme de détérioration physique et psychologique; ces vignettes décrivent des formes primitives de symbolisation au cours du refoulement primaire, et le rôle de l'action dans le développement affectif.

Dem Begriff der primären Verdrängung, der lange Zeit einn unbrauchbarer und undeutlicher Begriff war, ist in der jüngsten Neu-Bearbeitung der Verdrängungstheorie (Cohen u. Kinston 1984) ein ganz bestimmter Platz eingeräumt worden, und in dieser Arbeit werden sowohl seine Eigenschaften als auch seine Erscheinungsform spezifisch untersucht. Die Primäre Verdrängung bezieht sich auf die Abwesenheit der psychischen Struktur, die im Laufe der psychischen Entwicklung wiedergutgemacht werden kann. Das ist der Teil des Geistes in dem das Trauma weiterlebt, und er ist eng mit dem nicht verdrängten Unbewussten verbunden. Das unmittelbare Auftauchen der primären Verdrängung ist lebensbedrohend, sie zu aktivieren ist daher riskant. Während einer Psychoanalyse wird die primäre Verdrängung normalerweise mit Hilfe des Objekt-Narzismus, von neurotischen Abwehrmechanismen untermauert, vermieden. Sie ist jedoch, in der Anwesenheit einer nicht internalisierbaren, bejahenden und haltenden Beziehung, die wir als 'primäres Gebundensein' (primary relatedness) bezeichnen, erreichbar und bearbeitbar. Diese Beziehung ist daher der zwischenmenschliche Kontext für die psychische Entwicklung. Zahlreiche klinische Beispiele werden dargeboten, um die typischen Merkmale dieses Bereichs des Geistes, vom psychoanalytischen Gesichtspunkt aus, darzulegen. An Hand von Vignetten werden die Erfahrungen des Patienten und des Analytikers, und die Art und Weise wie sie eine Beziehung 'primären Gebundenseins' herstellen; das darauffolgende wiederauftreten von traumatischen Zuständen und nicht gedeckten Bedürfnissen, nicht selten in Form schweren physischen und psychischen Verfalls; primitive Symbolisationsformen im Laufe der Wiedergutmachung der primären Verdrängung; und die Rolle, die das Handeln in Bezug auf die psychische Entwicklung spielt, erläutert.

En una reciente reformulación de la teoría de la represión (Cohen & Kinston, 1984), el por mucho tiempo obscuro e inaplicable concepto de represión primitiva recibió un lugar preciso; y este artículo examina específicamente sus propiedades y manifestaciones. La represión primitiva se refiere a una ausencia de estructura psíquica que puede hacerse positiva en el proceso de crecimiento emocional. Es una región de la mente donde el trauma persiste: y tiene una conección estrecha con el inconsciente no reprimido. La emergencia directa de la represión primitiva es una amenaza para la vida y su activación es por lo tanto riesgosa. Durante el Psicoanálisis, la represión primitiva es evitada normalmente por el narcisismo objetal sostenido por defensas neuróticas, pero puede llegar a trabajarse en presencia de una relacion valiosa y nutricia no internalizable que designamos como 'vínculo primario'. Esta relación es, por lo tanto, el contexto interaccional para el crecimiento emocional. Se presentan numerosos ejemplos clínicos para demostrar rasgos propios de esta región de la mente tal como es vista por el psicoanálisis. Se ilustran experiencias de paciente y analista al establecerse el vínculo primario; la consiguiente re-emergencia de estados traumáticos y necesidades insatisfechas, al principio con frecuencia bajo la forma de deterioro psicológico y fisico severo; formas primitivas de simbolización durante el proceso de reparación de la represión primitiva; y el rol de la acción en el crecimiento emocional.

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APPENDIX

The technical approach implicit in this paper is easiest to associate with a particular, and to some unorthodox, line of psychoanalytic development from Ferenczi, through Balint and Winnicott, to Khan and Kohut. However examples of patients who require action or other radical non-interpretive activity or whose own action is facilitated inside or outside the session are now abundant in the clinical literature. Moreover, much of our argument seems to be unofficially accepted without being theoretically integrated into psychoanalysis. Virtually any issue of the *International Journal of Psycho-Analysis* in the past decade will yield many confirmatory examples. We have drawn the following from Parts 1 and 2 of Volumes 61 (1980—New York Congress Papers)* as evidence that active response to needs, correction of experiential deficit and transformative action are normative not unorthodox.

Example A:

Joseph (pp. 1–9), in his Presidential Address, emphasized that psychoanalyses in practice deviated from an ideal, presumably as laid down by orthodox theory: 'Ideally, the psychoanalytic candidate should be analysed in accord with all existing theories ... available ... Practically this does not take place for a multitude of reasons, including, of course, the fact that each human personality presented on the couch must be psychoanalysed in accord with his particular needs' (p. 5). If it is 'a fact' that a psychoanalyst 'must' adapt to the 'particular needs' of the analysand, then we propose that this fact should be part of, even prominent in, psychoanalytic theory.

Example B:

Blum (pp. 39–52) described the analysis of 'a young mother in her thirties ... an intelligent, thoughtful, attractive woman with a lively wit, considerable ambition, and many interests and friends' who had been traumatized by the death of her father when she was 4. Analytic work reactivated the mourning process and at its height it spilled over from the 'transference situation ... into real life and into the waiting room ... on one occasion (she) sat weeping in the waiting room for some time, both waiting for the analyst to offer more time and support and at the same time to tell her to leave and to function independently' (p. 44). Blum does not say how he handled this difficult situation. But his vignette supports our view that when trauma is being re-experienced, the analyst, however, classically inclined, will be routinely put into situations where interpretations are insufficient and his deliberate actions move to the centre of the therapeutic stage.

Example C:

Brenman (pp. 53–60) described the analysis of a young woman who presented with suicidal depression, helplessness and total inability to work. 'Her parents maintained a keen academic interest in psychoanalysis and were alleged to have "analysed" the patient with "sweet reason" as far back as she could remember. From childhood she had undergone different analyses over many years' (p. 55). Brenman rapidly discovered that the act of analysis—conventional interpretation—was the traumatic event. He wrote: 'I found myself making more extra-transference interpretations than usual, but it seemed to be the only means of reaching her' (p. 56). Brenman described this as 'a kind of acting out' on his part. The next significant piece of analytic

* These papers are not included in the Reference List.

work was based on action by the patient outside the session about which the analyst wrote: 'the fact that (it) had been enacted and survived seemed an important experience for her' (p. 57). This experience was part of a needed relationship which she had not had with her parents. Furst, in his summary of the Congress, put it explicitly: 'for Brenman ... the analyst's primary function is... to provide the patient with the experience of an understanding, real, current object who replaces faulty introjects' (p. 229).

Example D:

D. Rosenfeld (pp. 71–83) described analyses of patients with active perversions who apparently comply with psychoanalytic conventions. The compliance is in fact a complex form of self-protection and apparently good interpretive work by the analyst may play into this and lead to a stereotyped form of resistance. In the cases used to illustrate this phenomenon, anything the analyst said tended to be treated as an action and became in the transference a collusion with perverse desires. For example, words used by the analyst like 'sexual pleasure' were equivalent to his being excited. Rosenfeld suggested deliberate action by the analyst: 'The most convenient solution is to adopt an obsessive interpretive style, with an optimal schizoid distance, using words which are significant from the linguistic point of view, but abstract enough for the patient to be able to listen to them' (p. 77). Such an attempt to alter deliberately the analysand's experience of the analyst is not part of orthodox technique.

Example E:

Blos (pp. 145–151), in discussing the special nature of the transference in the psychoanalysis of adolescents, emphasized that repetition not only reflects a fixation, but is also an attempt to transcend past problems through psychic reorganization. Analysis thus becomes part of the developmental process and 'every successful adolescent analysis contains elements of identification with the analyst as a therapeutic vehicle and represents therefore, even if only marginally, a transference cure; its lasting curative effect is demonstrable in follow-up studies' (p. 148).

Example F:

Lussier (pp. 179–185) described the analysis of a 12-year-old boy with severe congenital hypoplasia of both arms, who 'seemed to have been more in need of the confidence of his mother than in need of normal arms'. He had a prolific fantasy life which was understood by the analyst as an attempt to give himself what his mother failed to provide in terms of confidence and encouragement. In the analysis, Lussier found that the boy's 'main projects or daydreams had to become reality during the analysis and even more, they had to become true within the analytical sessions. One of his aims was to come and play the trumpet for me. Which he did.' 'You might be thinking', continued Lussier, 'that this trumpet playing during the sessions could hardly be called free association and that we are dealing here with some sort of "corrective emotional experience". I would not entirely agree with this last part. It is true that I could not and did not want to hide my admiration and praise ... I do believe that his analysis proper would not have been possible, had he not filled up, to some degree in the transference, the primary emotional gap of his early childhood' (p. 180).

Example G:

Yorke (pp. 187–193) described the analysis of a professionally successful 28-year-old man, blind since childhood, who sought treatment because of serious inhibitions in his personal relationships. He tended to regard his blindness as the source of all his difficulties in spite of abundant evidence to the contrary. Yorke 'found that he (the analyst) had to operate as an auxiliary ego, as a source of reality testing, in order to undermine those coping mechanisms which put the blindness at the centre of every difficulty. He had to do this firmly, albeit with tact and discretion. He had to provide a model of frankness with which the patient could in time identify' (p. 189). Such conscious role-playing is ordinarily considered the paradigm of non-psychoanalytic, as distinct from psychoanalytic, treatment.

Example H:

Klauber (pp. 195–201) explicitly challenged conventional wisdom: 'Is it really true that only transference interpretations are "mutative" and that all others, or almost all others, are only a preparation? My own opinion is that it is not ... Strachey's stress on the therapeutic importance of introjection of the analyst and his implicit values sits uneasily in his framework, which is oriented to energetics rather than to relationships and values. It seems to me clear that some additional description is needed of what happens in the object-relationship of patient and analyst when a successful interpretation is formulated.' Klauber then goes on to refer to the analysis of a woman which he felt called for extensive extra-transference discussion in which her complex and contradictory value system was explored. In summarizing his paper, Klauber emphasized that personal contact with the patient is essential for development and suggested that anxiety-generating adjustments of psychoanalytic theory are called for.

Example I:

Ornstein & Ornstein (pp. 203–211) discussed work with a professional woman in her early thirties, who came to analysis complaining of an 'inability to be committed to anyone or anything... or to have deeply-felt emotional responses or experiences'. She described her inability to feel strongly 'as if she had a "gaping hole" in her psyche'. Following the report of a death of one of her cherished pets, the analyst replied 'I am sorry to hear that' and attempted to interpret the loss of the pet in terms of childhood loss of her mother.

This conventional neutral response and genetic interpretation led the patient to be convinced that the analyst did not like animals and was ridiculing her pain. This conviction persisted for several sessions until the analyst retracted and admitted that he had in fact by-passed the patient's current feelings and thereby recreated the past trauma. Following the analyst's recognition, deep sadness emerged and then conventional reconstructive interpretations were again useful. The authors argued that, because the patient had been failed in the past, 'she insisted that she be heard this time'. They also suggested that the analyst's failure in empathy, a paradoxical form of non-interpretive action, often unlocks the crucial trauma.

Example J:

Modell (pp. 259–267), discussing the non-communication of affects, recognized that important non-articulable needs and states of being caused by trauma may be presented to the analyst for recognition and for his human response. 'For example, there are patients who need to arouse an affective response in us and therefore may precipitate a series of external life crises. In an obvious sense this is a need to learn whether or not we care, but in a more fundamental meaning [sic] may be the wish to induce affects in us which they may then share vicariously to relieve the sense of emptiness and deadness of the self' (p. 260).

Examples from the contemporary literature could be proliferated at will, but the selection here and in the body of the paper includes writers from Europe, North and South America, from classical, Kleinian, and other schools. Although the clinical presentations of the patients are handled and justified within different frameworks, three unifying similarities are noticeable. These analysts appear, almost as a matter of course, to support the notion of meeting the analysand's needs; they find, sometimes despite themselves, that action by the analysand plays a crucial role in the cure; and they provide their analysands with important new experiences.

The examples provided show further interesting commonalities, which we suggest are due to the absence of any current theory explicitly addressing the above clinical phenomena. First, the psychoanalysts typically present their work as examples of special cases based on and justified by the special requirements of adolescence, physical disability, borderline pathology, narcissistic disorder, psychotic states, perversions, communicative disturbance in neurosis, character problems, psychosomatic illness, special trauma in infancy and so on. Second, the analysts tend to write in an apologetic, uncertain, or defensively assertive tone as they admit to having been led to fail their patients, or to deviate from the technical ideal of neutrality, or to abandon transference interpretation as the prime vehicle of therapy. Third, the analysts are not young radicals, but among the most senior and respected members of the psychoanalytic movement.

Our researches have grappled with this general clinical consensus amongst psychoanalysts and have led us to a simple theoretical conclusion. Without dismounting interpretation from its special place in therapy, it must be recognized that, in the realm of primal repression, wish and conflict have no meaning. In this region of the mind, all that can be seen are traumatic states, primitive symbolic activity, and unmet needs. Interpretation must give way to recognition and action as a deliberate strategy if understanding (psychic growth, deep insight, structural change) is to develop. This is not to give the analyst *carte blanche* to gratify, enact with, or fail patients. Rather the reverse. Our proposition is that it is only when primal repression and primary relatedness are activated, with all the work and risk that entails, that traumatic reliving and neediness make such demands on the analyst. Understanding and recognizing this phase in an analysis has been the prime aim of the paper. The aim of the Appendix has been to show that the views presented are implicitly widely accepted.

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