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THE BIPOLAR CAUSALITY OF REGRESSION

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> The illness followed close upon the fulfillment of a wish and put an end to all enjoyment of it. . . .
>
> At first sight there is something strange about this; but on closer consideration we shall reflect that it is not at all unusual for the ego to tolerate a wish as harmless so long as it exists in phantasy alone and seems remote from fulfillment, whereas the ego will defend itself hotly against such a wish as soon as it approaches fulfillment and threatens to become a reality.
>
> Sigmund Freud (1916/1957)
> "Those Wrecked by Success," pp. 317–318

> Like Polycrates, the ego sacrifices success in order to avoid the evil of death, or at least to put it off.
>
> Otto Rank (1936/1972)
> *Will Therapy and Truth and Reality*, p. 188

Human beings exist in a state of conflict: On the one hand, they have powerful drives to fulfill their potential as unique and independent individuals, and on the other they have self-destructive and self-limiting tendencies and strong unconscious desires to be taken care of. People usually feel the best emotionally when they are experiencing a clear sense of self and personal identity, yet these occasions are often fraught with separation anxiety and consequently are of brief duration. The process of regression described in this paper is related to this fundamental conflict between the drive toward assertion and separateness and the unresolved need to remain dependent and fused with another.

Clinicians have long recognized the importance of negative environmental influences and interpersonal stress as causative factors in regression; however, they tend to underestimate the importance of positive events. Unfortunate events such as financial loss, poverty, illness, divorce, or the death of a parent or sibling do contribute to regression; nonetheless, success—personal, professional, or financial—a satisfying love or sexual relationship, marriage, and parenthood are also primary factors in precipitating regressive trends.

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Indeed, regressions characterized by personal setbacks in psychotherapy, failure experiences, and prolonged periods of anguish are more likely to have been activated originally by positive movement toward individuation than by negative occurrences. Moreover, reactions of this sort are more likely to be overlooked or misunderstood because at first glance they do not fit conventional logic.

The purpose of this paper is to focus on this bipolar causality of regression and to delineate the crucial events in a person's life, both positive and negative, that tend to activate regressive trends. As the therapist becomes acquainted with the specific conditions in each patient's life that have symbolic meaning relevant to the trauma of separation and death anxiety, he or she can begin to sort out the complex causality underlying patients' regressive responses to these events.

REGRESSION AS A DEFENSE MECHANISM: BRIEF DISCUSSION OF THE LITERATURE

Regression has been defined as a return to earlier levels of development. In adult individuals, it is manifested in more primitive levels of behavior (Chaplin, 1975).

Sigmund Freud (1905/1953) originally linked the types of childish behavior manifested by regressed individuals to the arousal of separation anxiety due to loss of the love object. In his discussion of the defensive function served by regression, Freud wrote:

> An adult who has become neurotic owing to his libido being unsatisfied behaves in his anxiety like a child: He begins to be frightened when he is alone . . . and he seeks to assuage this fear by the most childish measures. (p. 224)

The author conceives of regression as the defense mechanism that is used to heal the fracture in the original bond with the mother/parent caused by events, symbolic or real, that remind one of being separate and vulnerable to death. As such, regression represents an unconscious decision to return to a state of imaginary fusion with the mother/parent.

The tendency to regress starts early in life with the infant's dawning realization of his existence separate from the mother. The author's description of man's emotional response to progressive separations from the maternal figure is similar to Otto Rank's (1936/1972) theoretical approach to regression:

> Analytic separation becomes the symbol of separation in general, which is one of the fundamental life principles. . . . All . . . steps on the way to self dependence, such as weaning, walking, and especially the development of the will are conceived always as continuous separations, in which the individual even as in the last separation, death, must leave behind, must resign developmental phases of his own ego. (pp. 72–73)

Rank believed that "the authentic meaning of the therapeutic process . . . comes to expression only in the end phase," that is, in the termination of therapy. He focused his attention on the dynamics of the ending phase because he believed that the patient's reactions to the anticipated separation from the therapist revealed the core neurotic conflict. Rank recognized that the patient tended to regress immediately prior to this crucial separation. He was aware of the patient's desire to remain ill and dependent on the therapist, which expressed itself in repeated efforts to prolong the therapeutic process by reverting to old symptomatology.

The author concurs that patients who are approaching termination in therapy revert to symptom formation because of their fear of ending the therapeutic fusion relationship. In this sense, they are reacting adversely to the positive event of becoming healthy and happy and feeling in better control of their lives. In the therapeutic situation, the patient's good feelings about change and improvement paradoxically lead to inevitable problems of separation.

A number of other theorists have called attention to the phenomenon of regression used as a defense against therapeutic progress, notably Michael Balint and Sandor Ferenczi. In his classic study of regression, *The Basic Fault*, Balint (1969/1979) observed that at a certain point in the therapy patients begin to expect the therapist to satisfy long-repressed primitive desires, anxieties, and needs from the past. According to Balint, these patients demand that their needs be gratified and their fears of separation be allayed through a symbiotic fusion with the therapist:

> What is expected from the object, the analyst, is for him to respond in a manner reminiscent of primary substances, that is, to allow the patient to enter with him into a form of primary relationship or *primary object-love*. [italics added] (p. 148)

Ferenczi (1931/1955), who was well-known for his warm, empathic approach, viewed regressive states as inevitable in patients who had improved in psychoanalysis:

> When you consider that, according to our experience hitherto and to the premises with which we start, most pathogenic shocks take place in childhood, you will not be surprised that the patient, in the attempt to uncover the origin of his illness, *suddenly lapses into a childish or childlike attitude*. [italics added] (p. 131)

> So far as my experience goes . . . there comes sooner or later (often, I admit, very late) [in the therapy] a collapse of the intellectual superstructure and a breaking

through of the fundamental situation, which after all *is always primitive and strongly affective in character.* [italics added] (p. 140)

In *Psychotherapy: A Basic Text,* Robert Langs (1982) reported regressive phenomena related to other features inherent in the therapy situation. He observed that patients often have negative therapeutic reactions, not only to the rules, the set boundaries, and the termination of therapy, but also to the positive dimensions of being treated sensitively and listened to empathically. In discussing these seemingly paradoxical defensive reactions, Langs stated, "Major sources of danger and anxiety accompany the secure therapeutic contract" (p. 328).

It is generally agreed that all psychotherapies promote regression in some form. The unique qualitative experience of being accepted and taken seriously by an interested person arouses separation anxiety from family and stirs up deep feelings of unresolved conflicts and repressed material from earlier developmental stages in the patient's life.

James B. McCarthy (1980) has also emphasized the roles played by separation anxiety and the fear of death in fostering regressive trends in patients. In *Death Anxiety: The Loss of the Self,* McCarthy explores the defensive maneuvers utilized by patients who attempt to form an illusory connection with the therapist:

The wish for fusion and merger denies the reality of separation and, thus, the reality of death. In idealizing transferences, the patient's insecurity discloses the wish for parental protection from that anxiety. (p. 201)

One measure resorted to by the regressed individual is to form a bond,[1] a dependency relationship with a significant other, in which an illusion of connection and of being taken care of prevails (Firestone, 1984).

Hellmuth Kaiser's (1956/1965) concept of a delusion of fusion as the universal psychopathology is analogous to our concept of a bond as the core defense against separation anxiety. In his descriptive analysis of patients' propensities to try to fuse themselves with the therapist, Kaiser stated:

As long as the patient's interest in the therapist is not too intense, the patient can behave in an approximately adult fashion. When his interest increases beyond a certain limit the adult relationship becomes intolerable for the patient. Closeness as it is accessible for an adult illuminates more than anything else could the unbridgeable gap between two individuals and underlines the fact that nobody can get rid of the full responsibility for his own words and actions. Then is the time when the patient tends to form with the therapist what one could call a "fusion relationship." (p. xix)

Kaiser originally described this symptomatology as being regressive, but later discarded psychoanalytic terminology for a more empirically based theory of psychotherapy. He goes on to say:

As his adult intellect does not allow him to maintain an illusion of unity he does something which is a compromise between fusion and mature relationship. Namely, he behaves either *submissively or domineeringly.* (p. xix)

In Kaiser's terms, the regressed individual or the typical neurotic patient either complies with and defers to authority, or he acts out a critical, parental role of false strength. Neither one represents a genuine *adult* response.

Jurg Willi (1975/1982) also noted manifestations of exaggerated polarity in marital relationships in which one partner assumes the role of the regressed child and the other takes the part of the pseudomature parent:

In the disturbed partner relationship we often observe that one partner has a need for over-compensatory progression while the other seeks satisfaction in regression. (p. 24)

This progressive and regressive behavior is a major reason for the mutual attraction and the resulting bond. (p. 56)

THE SPLIT EGO IN REGRESSION

The type of retreat characterized by either the authoritarian or dependent reactions described by Kaiser, Willi, and the author (1984, 1985, 1987) appears to reflect an internal division or split in ego functioning. Object relations theorist W.R.D. Fairbairn and his interpreter, Guntrip (1969), have emphasized that a "nonfacilitating" environment leads to "ego-splitting" with the eventual formation of a "regressed ego." Guntrip has suggested that the process of ego-splitting is "the basis of all regressive phenomena." Further splitting leads to the formation of a libidinal ego and: "an *antilibidinal ego* based on an identification which reproduces the hostility of the rejecting object to libidinal needs. . . . *The infant has now become divided against himself*" [italics added] (p. 72).

Psychoanalysts, in general, have become increasingly aware that the split ego is alien or antithetical to the core self and serves a defensive function, and that its dominance in the personality leads to serious pathology and regressive trends. The author's conceptualization of the voice process[2] points out the sources of the self-punishing and self-parenting aspect of the split ego in the negative parental attitudes incorporated by the individual during childhood. When this thought process or destructive "voice" prevails over thoughts of rational self-interest, severe regression often occurs, accompanied by strong self-destructive tendencies.[3]

It is the author's hypothesis that the longing to merge with the parental figure (or its substitute) is an individual's most basic response to fear of separation and anxiety about death and that this anxiety is aroused by both positive, gratifying experiences and negative, traumatic events. The tendency of human beings to revert to patterns of distorted thinking and immature behavior that support an illusion of connection with another person is universal and occurs whenever the fear of separation, aloneness, and death overwhelms the ego (Firestone, 1985).

In discussing the broader implications of this universal human propensity, Murray Bowen (1978) has emphasized the fact that societies, as well as individuals and families, regress and gravitate toward fusion or "togetherness" in response to chronic anxiety:

> Togetherness forces begin to override individuality, there is an increase in decisions designed to allay the anxiety of the moment, an increase in cause-and-effect thinking, a focus on "rights" to the exclusion of "responsibility," and a decrease in the over-all level of responsibility. (p. 279)

If we are to interrupt regressive trends and modify self-destructive, acting-out behaviors in our patients, we must first be able to understand the outward manifestations of the fantasy bond that are at the core of these phenomena. Furthermore, it is important to identify the stages through which an individual passes in his retreat from positive circumstances and success.

EARLY REGRESSION RELATED TO SEPARATION ANXIETY

The original bond or fantasized fusion with the mother is formed as a response to infantile frustration, the all-encompassing pain and the fear of annihilation experienced by the infant at times of stress and during separation experiences. The primitive illusion of connectedness alleviates pain and anxiety by providing partial gratification of the infant's emotional or physical hunger (Firestone, 1984). The fantasy of being fused with the mother's body, particularly the breast, acts to protect the child against an awareness of being separate and alone.

Even during very early stages of development, the child's fears are partly relieved as he becomes more adept at calling up an image of his mother whenever he feels threatened (Mahler, 1961/1979; Winnicott, 1958). The primary fantasy bond, together with primitive, self-nourishing behaviors such as thumb-sucking, rubbing, stroking a blanket or special toy (and later masturbation), helps the child cope with anxiety reactions. These self-parenting behaviors offer temporary relief but tend to become addictive.

The more deprivation there is in the infant's immediate surroundings, the more dependency there is on this imagined connection. This sense of being at one with the mother leads to feelings of omnipotence and a posture of pseudoindependence in the growing child ("I don't need anyone; I can take care of myself"). The illusion of self-sufficiency, of being able to meet his own needs without going outside himself, is actually a desperate attempt on the child's part to deny his true state of helplessness and vulnerability.

THE RELATIONSHIP BETWEEN SEPARATION ANXIETY AND FEAR OF DEATH

At a certain stage in the developmental sequence, separation anxiety becomes associated with the knowledge and dread of death. Our clinical experience has shown that children progress through several stages in their discovery of death. In the initial phase, the child attempts to avoid the new threat to his security by regressing to an earlier stage of development, a level at which he was unaware of death. He reinstates the imagined connection with his mother and utilizes the self-parenting process to reassure himself that even in the event of his parents' death, he can take care of himself.

Still later, the child becomes aware that he cannot sustain his own life. Unable to bear the prospect of losing the self through death, he retreats to a previous level of development and reaffirms the bond with the parental image. In other words, psychological defenses that were formed originally in response to emotional deprivation, rejection, and separation trauma are strengthened by the growing awareness of death.

The fear of death now becomes the driving force behind regressive behavior and the formation of dependency bonds. Thereafter, any negative event or reminder of death, such as illness, rejection, or accident, can precipitate regressive trends in an individual. In addition, any positive event or evidence that heightens a person's awareness of being separate, of being a free agent, can foster regression. Indeed any experience that reminds an individual that he possesses strength, independence, personal power, or acknowledged value as a person will make him acutely conscious of his life and its eventual loss. In that sense any development that breaks a bond or threatens an illusion of being connected to another can be perceived as a life-threatening situation.

The seemingly perverse, hostile, or provoking behavior often directed toward those who love, befriend, or choose us is understandable in relation to the issue of death anxiety. As we are chosen or valued, we are drawn into a greater emotional investment in a life that we must certainly lose. We fear this increased sense of vulnerability and will often act out destructive responses that interfere with closeness and intimacy.

In the face of this perceived threat, people give up mature, goal-directed

behavior and genuine relating for a more childlike orientation. They retreat into dependent, destructive bonds with significant others in their interpersonal relationships. Furthermore, whenever there is progression to a new stage of individuation brought about by crucial life events such as leaving home for the first time, getting married, starting one's own family, or achieving an important personal goal, an individual becomes acutely aware of both existential issues, his basic aloneness and the temporary quality of his life. In this sense, neurotic regression connects to a very *realistic* fear: the terror and anxiety that surround a person's awareness of death.

THE RELATIONSHIP BETWEEN SEPARATION AND GUILT IN PRECIPITATING REGRESSION

Both guilt feelings and fear arise when there is a threat of separation, either real or symbolic. Each phase in an individual's development toward maturity is marked by guilt at leaving the mother (parents) behind and by anger and resentment at having to face the world alone (Firestone, 1987). Indeed, many parents experience considerable distress at their child's growing independence and openly indicate their displeasure and disapproval. The child or adolescent senses the parents' pain or grief over the anticipated loss and responds with guilt.

Otto Rank (1936/1972) was well aware of guilt reactions in relation to the problem of "will." The author's understanding of the role that neurotic guilt plays in imposing constrictions on an individual's life-affirming activities is in accord with Rank:

> The neurotic comes to grief, where, instead of living, of overcoming the past through the present, he becomes conscious that he dare not, cannot, loose himself because he is bound by guilt. (pp. 73–74)

Patients who progress in psychotherapy are often undermined by guilt reactions after they have contact with parents or other family members. Many report that successes in therapy and in their personal lives made them aware of their parents' limitations and disturbed style of relating. Having a more realistic or objective view of their families triggered intense feelings of guilt. Guilt reactions related to "winning" over a rival, being chosen or preferred, being acknowledged for a success for which others were striving, or significant movement in therapy, lead to self-recriminations and self-attacks. Fears of retaliation and a sense of being somehow responsible for the rival's "downfall" or humiliation also contribute to a person's tendency to retreat from goal-directed behavior. These painful feelings are reduced when a person regresses and adjusts his performance downward so as to diminish or sabotage his own success or achievement.

EPISODIC REGRESSION DUE TO POSITIVE EVENTS

As described earlier, positive events may be even more important than negative ones in triggering the onset of a regressive trend. In general, any positive event that indicates a change in a person's identity, that disturbs his psychological equilibrium, that emphasizes his difference from the family, especially from the parent of the same sex, or that fulfills an important personal goal, has the potential for precipitating a long-term regression.

Nonconformist actions or even merely expressing one's point of view in the face of controversy can generate fear and guilt, which in turn can lead to regression. Similarly, a person who begins a romantic love affair is risking a great deal emotionally. His sense of being vulnerable arouses considerable anxiety and can induce a return to a more isolated, pseudoindependent posture. Reaching sexual maturity can also trigger regressive reactions. For example, a woman who is able to experience orgasm after many years of suffering with problems in that area may revert to immature behavior in other areas of her functioning.

Serious, long-term regression can also occur in reasonably well-adjusted individuals when they experience an atypical success or achievement (Firestone, 1987).[4] Numerous examples of incompetency, inadequate performance, and the onset of various forms of self-destructive behavior following the achievement of public acknowledgment, an important promotion, or the assumption of an executive position have been well-documented in the literature (Clance and Imes, 1978).[5]

STAGES IN THE REGRESSIVE PROCESS FOLLOWING POSITIVE EVENTS

The author has noted several stages in regressive episodes.

Initial Reaction

After a significant accomplishment, an individual generally experiences feelings of excitement and a sense of personal achievement. There is an inner glow of satisfaction, a feeling of exhilaration, optimism, and a sense of expanded boundaries. There are feelings of appreciation and gratitude toward the agent (the individual or individuals) who contributed to one's success. There are positive feelings toward the love object who chose the person in a rivalrous situation. The degree or intensity of an individual's initial excitement varies according to the personal meaning he attributes to the event and its implicit meaning about his identity.

However, immediately following a positive experience, there is an exaggerated sensitivity to negative feedback or potentially adverse reactions. In this

state of acute awareness, a person tends to scan the interpersonal environment, searching for the slightest sign of disapproval or censure. In this manner, one's perceptions and emotional reactions become finely attuned, and there may be powerful mood swings following an unusual success.

Self-Consciousness: A Precursor to Guilt Reactions

Feelings of self-consciousness are aroused if the positive event is especially meaningful or represents the fulfillment of a lifelong fantasy. These unpleasant emotions may arise almost immediately (in stage 1), or they may come about gradually. Moreover, extraordinary success arouses reactions of admiration, envy, or resentment from others. These ambivalent responses elicit painful feelings of self-consciousness in the achiever and alert a person to differences between his peers and himself. Minor criticisms or competitive remarks from rivals contribute to the individual's tendency to observe himself with unfriendly eyes, which enhances his discomfort. Feelings of self-consciousness are exacerbated by public acknowledgment of one's success and by symbols of accomplishment, such as a promotion or a raise. As the person continues to move toward success and greater accomplishment, he will experience guilt reactions in relation to symbolically leaving others behind, disrupting ties with the family, or to surpassing a parent's level of achievement.

Anxiety and Fear of Loss

Anxiety reactions, due to a deep fear of object-loss, become progressively more unpleasant and painful. As a person achieves increased personal power, separation anxiety is intensified because he is symbolically moving *away* from sources of security in the family and among his peers. As there is movement toward individuality, there is a sense of increased ambiguity and uncertainty. The new events evoke fear reactions, and death anxiety tends to increase; indeed, thoughts about the inevitability of death become increasingly unacceptable or unpleasant as life becomes more precious and as the achiever recognizes his self-worth and value as a person. Patients often report having felt that life was "too good to be true" in enjoying the thrill of significant success or personal growth. Paradoxically, achievement and increased fulfillment make people more aware of potential losses and of the inevitable loss of self through death.

Actual Retreat

Feelings of depression arise as anxiety and guilt reactions are translated into regressive, childlike behavior. The individual increasingly turns against personal goals, wants, priorities, *and* against the agents of his success. This stage is characterized by intense self-attacks as well as angry, cynical thoughts about the person or people who were supportive. Interestingly enough, these self-hating and hostile ruminations appear to *reduce* painful feelings of anxiety, yet they invariably lead to disillusionment with self and depressive reactions.

In addition, during this phase, many individuals tend to increase their reliance on drugs, alcohol, food, or other addictive habit patterns in an effort to relieve intense anxiety states. However, these indulgent, self-nourishing responses interfere with one's ability to cope and lead to painful feelings of existential guilt[6] that have a profoundly demoralizing effect on the individual. An almost imperceptible retreat into dependent, immature functioning and self-defeating behavior commences as the person *gradually* withdraws from the position of power that he recently attained. Moreover, there is a concomitant failure to pursue other adult goals. Many people are largely unconscious of how much their energy, motivation, and drive to achieve have diminished. Others rationalize their loss of enthusiasm and motivation by attributing it to external circumstances.

Regression to Fusion Relationships and Self-Nourishing Habits

Regression is fully established as the patient retreats to a more primitive or less mature level of adjustment, thereby minimizing or eradicating his success or uniqueness. Efforts are directed toward reestablishing a sense of *sameness* with one's family and other significant figures in one's life. Self-nourishing and self-destructive behaviors become routine or habitual and function to limit or invalidate prior achievements so that recent positive changes in identity or self-image are drastically reduced.

In general, the latest achievements and most profound changes in identity are the first to be renounced or sabotaged. As the regression becomes long-term, the patient may retreat several stages in his development and can become seriously disturbed and disoriented in diverse areas. Old defense mechanisms and childlike behaviors come to the foreground as the individual attempts to fuse with significant others in order to achieve a sense of security.

As previously noted, regressions are frequently misinterpreted as being adverse reactions to negative events. This common misinterpretation is understandable when one considers the fact that a patient's retreat after success provokes rejection from significant figures in the interpersonal environment. For example, as a *result* of regressive, childish, or incompetent behavior, the individual may come to actually lose a personal relationship, his position of power, or his job. Often, the *consequences* are mistaken for the *causes*. Many patients and therapists tend to trace the onset of the patient's suffering to the

occurrence of these negative circumstances, events that actually happened *after* the initial symptoms of the regression were manifested in the patient's behavior.

CASE HISTORY

Dr. S entered therapy several months following his divorce. His diagnosis was major depressive episode with indications of a compulsive personality disorder. For a number of years prior to the onset of his depression, Dr. S had served as a project leader in one of the country's most prestigious corporations. On one special project, he was in charge of over 50 scientists and system analysts, who for several months studied specific strategic positions and then arrived at a consensus. The project culminated in a proposal that Dr. S presented to the joint chiefs of staff in Washington, D.C.

According to the patient, his reception at the initial meeting was extremely positive, and he was personally acknowledged for making an important contribution to the country's overall defense program. In Dr. S's words, the enthusiastic responses "really shook me up." He recalled being very agitated and was unable to sleep that night.

The next day Dr. S summarized his ideas at a larger gathering of important officials. Again, the reaction was overwhelmingly positive, but there was one ranking officer who voiced some reservations. A meeting at which a final decision would be made was scheduled for several months in the future. Returning to Chicago, Dr. S feverishly set about correcting what he considered to be serious errors on his project. His exaggerated, peculiar focus on the minor criticism expressed during the second meeting, in spite of the overwhelming positive reactions, was symptomatic of this early phase in his regressive pattern.

Dr. S began to have doubts about his proposal achieving final acceptance. He worked long hours locked in his office, compulsively pouring over details of the next position paper he was to present in Washington. During this period, he started spending more evenings and weekends away from his family and increased his consumption of alcohol. His relationship with his wife gradually deteriorated as he began to prevail upon her to provide him with sympathy and support during the pseudodramatic crisis. His wife, who had always played the role of a dependent, incompetent child, refused to assume the adult "progressive" role suddenly being thrust on her.

Several months later, the project was shelved because of delays in Dr. S's work and outside budgetary considerations. At about the same time, his wife decided to leave him. The combination of events at work and the ensuing separation threw him into a state of agitated depression and confusion. It was at this point that he sought professional help.

In his therapy sessions, Dr. S recognized that the first signs of his retreat

from power had occurred immediately following the public acknowledgment of his leadership abilities, his influence over major policy decisions, and his competence as a scientist. These symbols of power were indications of a separation from the negative self-image and feelings of inferiority Dr. S had incorporated in early interaction with his family. Over the course of therapy, the patient recalled numerous degrading labels and negative traits attributed to him by both parents. He remembered his father predicting that he would "never amount to anything," and referring to him as a "bum," "ditchdigger," and "simple shit." Dr. S's mother, while not overtly degrading, nonetheless had focused on the patient's physical health, with constant reminders that he was too "sick" or "weak" to function as well as other youngsters.

Furthermore, being recognized as an authority in an important area of endeavor effectively placed the patient in a position far superior to that of his father, who had failed repeatedly in business and who was not admired in the community. Although his guilt at surpassing his father was primarily unconscious, Dr. S's compulsive, self-punishing work schedule represented an attempt to make retribution for this symbolic triumph. The significant success triggered a severe state of anxiety in the patient, resulting at first in sleeplessness but gradually developing into more of a paranoid state. He focused his attention on the minor criticism voiced by one individual at the second meeting, an incident that he mistakenly believed was responsible for his subsequent regression and misery.

In part, Dr. S's regression represented an unconscious imitation and identification with his father's pattern. On a deep level, it cemented the bond with his family. In therapy, Dr. S began to understand how this connection with his father affected his life. He recalled his father's paranoia toward other men, particularly authority figures. He developed insight into his own guilt feelings and compulsive behavior and related these patterns to the progressive deterioration in his ability to function adequately as a leader. As Dr. S developed awareness of the origin of his depression and compulsive work patterns, his depression eased. He gradually regained a sense of dignity and self-respect and gave up his excessive use of alcohol.

Severe episodic regressions, such as the one reported above, are not unusual for individuals who reach high levels of achievement, attain leadership positions, or pass specific milestones in life. Many people, like Dr. S, attribute their anxiety and the source of their troubles to outside forces and experiences rather than recognizing propensities for self-destructiveness within themselves. In the case of Dr. S, many months of working through the underlying causes of his regression were required before he could assimilate, on an emotional level, the drastic effects of his retreat from power and, from there, begin his slow recovery.

CONCLUSION

The bipolar causality of regression becomes more understandable when viewed as a reaction to the trauma of separation—the original separation from the parent at weaning and later the anticipation of the final separation from the self that occurs at death. Positive or especially fortunate circumstances—success, the attainment of mature love and sexuality—disrupt dependency bonds and make us acutely aware of valuing our lives. Good feelings and good times are frequently accompanied by moments of clarity and an unusual awareness of separateness and limitation in time. Positive experiences in real life as compared with fantasy gratification threaten the illusion that we are somehow immortal. Negative events, on the other hand, followed by demoralization, fit into the general regression theory. Their causal relationship to regression has always been more predictable and straightforward.

Most people live within a narrow range of experiences bounded by debilitating emotional responses to negative incidents and failures, on the one hand, and by adverse reactions to atypical positive events on the other. Successful psychotherapy broadens this range by helping patients minimize and cope with negative events and increase their tolerance for positive, fulfilling experiences.

NOTES

1. A bond, or fantasy bond, is defined in the author's writing (Firestone, 1985) as an *imaginary connection* originally formed between the infant or young child and his or her mother to compensate for emotional deprivation and separation experiences in the early environment. It should be distinguished from the concept of bond or bonding as used in the positive sense, as in maternal-infant bonding.
2. The voice refers to a system of negative thoughts toward self and others that is the fundamental cause of an individual's maladaptive and self-limiting behavior. It is an overlay on the personality that is not natural, but learned or imposed from the external environment. The concept of the voice and procedures of Voice Therapy are described in *Voice Therapy: A Psychotherapeutic Approach to Self-Destructive Behavior* (Firestone, 1988).
3. Self-destructive manifestations of the voice are described in "The 'Inner Voice' and Suicide" (Firestone, 1986).
4. *Microsuicide: A Case Report* (Parr, 1985) describes a regressive episode in a 26-year-old female patient (29-minute videotape). Excerpts from clinical material published in "Microsuicide and Suicidal Threats of Everyday Life" (Firestone and Seiden, 1987).
5. Holmes and Rahe (1967) in constructing their "life events scale" recorded cases in which the magnitude of critical life changes (both positive and negative) was related to an increased probability of bodily illness.
6. "The 'Voice': The Dual Nature of Guilt Reactions" (Firestone, 1987).

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