

ORPHA, ORPHIC FUNCTIONS, AND THE ORPHIC ANALYST: WINNICOTT'S "REGRESSION TO DEPENDENCE" IN THE LANGUAGE OF FERENCZI*

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Early developmental trauma is imprinted in the psyche by survival fragmentation and dissociation. Traumatized patients need the analyst to be actively involved and allow for regression to dependence in order to strengthen, create and construct their psychic functioning and structure so that environmental failures will be contained and not rupture continuity of being. I suggest that Ferenczi's and Winnicott's ideas about regression to dependence in analysis are fundamental contributions to these quests, and that Ferenczi set the foundation, which Winnicott further explored and developed. I would like to focus on their clinical theory of treating early developmental trauma of the psyche, describing it in the less known language of Ferenczi, reviving his concept of Orpha and its functions. The complementarities of the two approaches can enrich and broaden our understanding of the clinical complications that arise in the analysis of such states.

KEY WORDS: early trauma; dissociation; regression to dependence; Orpha; Orphic functions

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Contemporary psychoanalysts have been increasingly presented with patients whose difficulties and level of psychic functioning lie beyond neurosis. In these instances, the uncovering—of organized, but disguised or hidden, conflicts, fantasies, wishes, and compromise formations—is not curative. Rather, these patients need the analyst to actively strengthen or create and construct their psychic functioning and structure.

I suggest, in this paper, that Ferenczi's and Winnicott's ideas about regression to dependence in analysis are fundamental contributions to these

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quests, and that Ferenczi's laid the foundation, which Winnicott (among others, to whom I will not refer in this paper) further explored and developed.

Sandor Ferenczi (1873–1933) preceded D. W. Winnicott (1896–1976). The remarkable resemblance between the work of the two has been recognized by Winnicott himself. Winnicott mentioned Ferenczi only a few times, yet stated that “I never know what I’ve got out of glancing at Ferenczi,” presumably, because their thinking was so similar (Winnicott, Shepherd & Davis, 1989, p. 579). This was corroborated by Renata Gaddini, who recalled, while visiting the Israeli Psychoanalytic Society years ago, that Winnicott said that he didn’t not want to read Ferenczi because he didn’t know which was his own and which was Ferenczi’s².

In the present paper, I would like to focus on their clinical theory of treating early developmental trauma of the psyche, and to describe it in the less known language of Ferenczi. The complementarities of the two approaches can enrich and broaden our understanding of the clinical complications that arise in the analysis of such states.

First and foremost, these clinical implications evolve directly from their theory of early psychopathology. Both Ferenczi and Winnicott underscore the crucial prerequisite of adaptation of the environment to the development of the self, and both regard the dependence of the psyche on the environment at the initial stages as an axiom, thus seeing the impact of the environment on the psyche as the main factor for early psychopathology (Ferenczi, 1927, 1933; Winnicott, 1962, 1960).

Ferenczi does not explicitly differentiate early trauma into distinct and separate types, but rather, it seems to me, regards it as a continuum with variations in extent and in the means of survival (I will return later to his theory).

Winnicott, in his own classifications (1959, 1956), broadens these processes and differentiates between three groups, each requiring a different level of regression in analysis. The level depends on the development of the ego’s independency and to what extent it has been impaired, which consequently arouses a continuum gauging the intensity of annihilation anxiety:

The first group is that of neurotic patients who can be depicted as having reached a certain stage of emotional development (i.e., independence) that enabled them to have self-experience and symbolic representations, and their ego defenses to be organized. With such patients, the analyst may conduct a classic psychoanalysis based on interpretation.

The second group includes patients who can experience deprivation, since they have reached the level of relative dependency, and experience environmental deficiency as such “at the time of deprivation” (Winnicott, 1959, p. 134), so the deprivation can be perceived as traumatic. “The

pathology is primarily in the environment and only secondarily in the child's reaction" (p.135). The reaction to an external failure is by means of an intra-psychic distortion of the fragmentation into True and False Selves in order to maintain the crucial attachment to the other. In excessive failures, the true self is dissociated³ to the extent that the sense of being and sense of real are impaired. Fear of breakdown compulsively repeats this dissociated fragmentation so it can defend itself against unbearable annihilation anxiety.

The third group, the most impaired one, refers to psychotic (in Winnicott's terms) patients: for these patients, "emotional privation occurs at the stage before the individual could perceive a deprivation" (Winnicott, 1959, p. 133), because they have not yet reached a state of a unit and cannot differentiate between "me" and "not-me", and have not yet developed their defenses. Self states have never been experienced or are somatically "catalogued" (Winnicott, 1949, p. 247) and "unlived" (Ogden, 2014) by the mind that takes over the absent maternal functions (Winnicott, 1949). A False Self has to be established much too soon. Continuity of being is ruptured and disintegrated, annihilation anxiety exists, chaotic fear of breakdown infiltrates any sense of being, and unbearable primary agonies haunt the self. These are felt as deadness (same as Ferenczi, 1929), dread of disintegration and annihilation. This catastrophic rupture is instantaneously reacted to by disintegration (and fragmentation), which defend against the fear of a recurring breakdown, and entails an absence of any materialization of the authentic tendencies and potentials of the self: "a freezing of the failure situation" (Winnicott, 1954, p. 281⁴) occurs, expecting a new environment in which they will be able to be alive.

For the two "non-neurotic" groups, the intra-psychic trauma of rupture remains the core around which further psychic development transpires determining the degree of False Self. The "unlived" self and the fragmented and dissociated parts all turn to an intra-psychic "structure" that guards against "fear of breakdown", yet also enforces and retains this survivalist and adaptive structure of the psyche. Early psychic traumatic functioning differs from the mental rules that govern the more developed psyche. It is governed by a principle that lies "Beyond the Pleasure Principle" (Freud, 1920): that of repetition compulsion, and is not accessible to interpretation, as it has no representations (Roussillon, 2011).

Winnicott (1959) claims that

only the true self can feel real.... When the false self becomes exploited and treated as real there is a growing sense in the individual of futility and despair....only the true self can be analysed. Psycho-analysis of the false self, analysis that is directed to what amounts to no more than an internalized

environment, can only lead to disappointment. There may be an apparent early success....it is necessary for analysis to provide conditions which will allow the patient to hand over to the analyst the burden of the internalized environment, and to become a highly dependent but a real, immature, infant. Then, and only then, may the analyst analyze the true self (Winnicott, 1959, pp. 133–134).

Ferenczi (1928) similarly points out that

...it is the business of a real character analysis to do away, at any rate temporarily, with any kind of super-ego, including that of the analyst. The patient should end by ridding himself of any emotional attachment that is independent of his own reason and his own libidinal tendencies. Only a complete dissolution of the super-ego can bring about a radical change. Success that consists in the substitution of one super-ego for another must be regarded as transference success; they will fail to attain the final aim of therapy, the dissolution of the transference (Ferenczi, 1928, p.98).

Just as the psychic trauma originates from the environment, so is the concrete and actual other's involvement crucial for reviving the potential self states and dissociated parts. They both stress that the actual other, the analyst, is involved and "lives through" (an experiential way of "working through") the traumatic experiences with the patient. These basic assumptions of early psychopathology highlight the "exogenous origin....and emphatic stress on the traumatic factors in the pathogenesis of neurosis which had been unjustly neglected in recent years" (Ferenczi, 1933, p. 156), both in theory and in analytic praxis. Ferenczi's words are as relevant today as they were then.

REGRESSION TO DEPENDENCE

Regarding environmental failure as the origin of annihilation anxiety and of disruption in the continuity of being at the stage of dependence, Winnicott assumes that in analysis the analyst should provide a safe environment that will open the way to regress to dependence and should work through the original past failures as they recur in current analytic relations. These clinical implications allude to the realization that the analyst's crucial function is to serve as a concrete environment in the midst of which the internal impact of the early failure can be contained, and thus change. Returning in the concrete present to the experience of safety and assurance that preceded the failure is a prerequisite to acquiring the capacity to contain what has been just recently unthinkable. Actual failures of the analyst are curative if they are "in the patient's way" (Winnicott, 1963, p. 258) and acknowledged by the analyst. Thus the analyst allows for a new

development of the self. It is crucial for the patient to live and experience the fear of breakdown in the present with another who adapts and treats these mental catastrophes in an empathic way. This changes, in retrospect, the past impact on the self to “a renewed experience in which the failure situation will be able to be unfrozen and re-experienced” (Winnicott, 1954, p. 281).

Each patient follows his own pace and process and the analyst should adapt himself to them, so that “certain aspects of the environment which failed originally may be relived, with the environment this time succeeding instead of failing in its function of facilitating the inherited tendency in the individual to develop and to mature” (Winnicott, 1959, p. 128). This, by no means, is “a simple reversal of progress” (Winnicott, 1954, p. 281), but rather a process that gradually unfolds by the patient, working in the present through the environmental failures.

The analysis reproduces the early and earliest “good enough” mothering techniques that adapt to the patient’s needs (Winnicott, 1964). Hope for reviving dissociated parts and experiencing the True Self arise, and eventually the False Self is handed over to the analyst. This is a time of great dependence and true risk, and the patient is naturally in a deeply regressed state. This is also highly painful because the patient is aware, while the infant in the original situation is unaware, of the risks entailed. In some cases so much of the personality is involved that the patient must be in care at this stage. One characteristic of the transference at this stage is the way in which we must allow the patient’s past to be the present: the present goes back into the past, and is the past.

What follows is a process of building up an ability on the part of the patient to use the analyst’s limited successes in adaptation, so that the ego of the patient is capable of beginning to experience the original failures, all of which were recorded and kept ready. These failures had a disruptive effect at the time, and now the patient is able to feel them and to be angry in response. From the new posture of ego strength, anger, related to early environmental failure felt in the present and expressed, enables the patient to progress towards independence (Winnicott, 1954, pp. 289–290).

Being able to be angry at the analyst’s failures means that the patient makes use of them, and not that the patient is deteriorating or in resistance. There is no attempt to give perfect adaptation; rather, to expand the patient’s ability to experience the failure instead of being ruptured by it. “The analyst needs to be able to make use of his failures in terms of their meaning for the patient, and he must if possible account for each failure even if this means a study of his unconscious counter-transference” (Winnicott, 1956, p. 387). It is necessary for the analyst to look for his own mistakes whenever “resistances” appear.

If the analyst defends himself at this point, the patient misses the opportunity to be angry about a past failure just where anger was made possible for the first time. Here there is a great contrast between this work, with the two latter groups mentioned above, and the analysis of neurotic patients. It is here that we can see the sense in the dictum that every failed analysis is a failure not of the patient but of the analyst. "It is this part of the work that frees the patient from dependence on the analyst" (Winnicott, 1956, p. 387).

I will turn now to Ferenczi's earlier formulations about early trauma and its intra-psychic imprint. Ferenczi was the first psychoanalyst who regarded regression as a crucial requisite for depth analysis. I will adhere to Ferenczi's language of describing the analyst's quests for providing a facilitating environment that encourages regression to dependence, and thereby allows the revival of self states.

ORPHA⁵

Here I would like to resurface the concept of Orpha, which I consider to be vital to the view unfolded to this point. Orpha is mentioned only a few times (January 12th, January 17th, May 1st, and June 12th) in Ferenczi's Clinical Diary (Ferenczi, 1932), but captured my heart and imagination, as it has others,⁶ and can be regarded as an important cornerstone in Ferenczi's work. It is believed that he heard about Orpha from Elizabeth Severn, the most prominent patient in the Clinical Diary. Severn, who was interested in the occult and in spiritualism, told Ferenczi that her Orpha had found him for her and guided her to him so that he might rescue her.

Orpha is a Mythical poetical name for an innate life-preserving force that provides protective mothering in its excessive absence at the age of tenderness (similar to Winnicott's ideas (1949) that the psyche has an innate ability which allows the mind to take upon itself the absent maternal functions). Ferenczi claims that the initially dependent psyche becomes more suggestible (Ferenczi, 1932, Jan. 24th) as a shock reaction to any excessive absence of environmental adaptation to the child's needs for dependence and for tenderness. Instead of alloplastic (Ferenczi, 1927, 1928, 1933) adaptation (that of the environment to the infant's needs), the tender psyche is fearfully coerced to distort itself (autoplastic adaptation) and to survive the environmental excessive failure by automatic fragmentation and dissociation⁷ of both the authentic and the traumatized self.

Ferenczi referred to these intra-psychic distortions as resulting from an Identification with the Aggressor: when excessively not adapted to, the

child's psyche incorporates the other's annihilation of its needs, fearfully indentifying with it, so that it remains imprinted internally as intra-psychic absence of the authentic self, as well as of the traumatized child (Ferenczi, 1932). Into this internal absence infiltrates the will of the other, becoming an "alien transplant" (Ferenczi, 1932, April 7, p. 81) that "rules" from within. The external "aggressor" becomes an internal part of the psyche, which keeps the authentic and traumatized self dissociated, expressing itself in physical ways, in dreams, or in trance. A part of the psyche takes over the functions of the absent environment and is a guardian angel for the traumatized dissociated part. This internal organization repeatedly defends itself from every other (who is perceived as a potential aggressor that may repeat the annihilation of the psyche) by self annihilation of any arousal of the dissociated parts.

The anxiety of annihilation and psychic death which are aroused, call for Orpha to come forth and appear from the depth of despair and helplessness and, as if by magic, reignite the burnt embers of the soul, gather its dissociated fragments, and even "allows insanity to intervene" (Ferenczi, 1932, Jan. 12, pp. 8–10) for the sake of survival. In Winnicott's terms, Orpha would be a manifestation of the "innate capacity for self-cure" (Winnicott, 1959, p. 128), which allows for a false self to take over in order to survive, while taking upon herself the absent maternal functions. Ferenczi's concept means that Orpha is part of the False Self, as well. Orpha preserves consoling hallucinations, soothes psychic pain and shields the dissociated parts from further injury. These are the Orphic functions of the patient (Smith, 1999).

Yet Orpha is detached from any emotion, and is out of touch with her suffering. Even when managing to preserve the existence of the pre-traumatic psyche from destruction (Ferenczi, 1932, February 21, p. 39), this is achieved by means of fragmentation and dissociation, entrenching the Identification with the Aggressor and the False Self. This perpetuates and repeats a survival-oriented mode of existence, and lacks the necessary oxygen for the psychic healing and the revival of the dissociated self-states. Orpha cannot restore attachment.

In the language of Winnicott, we can refer to the intra-psychic pathological fragmentation as distortions of the ego between True and False Self. In these cases, the False Self not only protects the True Self from recurring fear of breakdown and annihilation, but also prohibits any revival of it. It keeps the un-lived and dissociated states in their survival mode.

For the dissociated parts to revive and be contained intra-psychically and for true intersubjective contact to be restored, helplessness and despair must be released from dissociation and re-experienced. Transformation occurs only when Orpha relinquishes her hold over the dissociated psyche, trusts the analyst to join her, surrendering her exclusive role and place to the

analyst, who now assumes her functions, yet without the cost of emotional detachment. This includes acknowledging his own failures and of their intra-psychic re-traumatizing impact on the patient. These, I suggest, are the analyst's Orphic functions.

A better idea of the complicated nature of these Orphic functions can be gained by a glimpse at the mythological background of the figure of Orpha. She is not mentioned in Robert Graves's *Greek Myths* (1955), and is not to be confused with the Biblical Orpha from the Book of Ruth, which is spelled differently in Hebrew and has no etymological link to it. Yet she is mentioned in Bryant's book about ancient Greek myths (Bryant, 1774–1776) as a goddess who was part of the ancient Orphic cult, a feminine version of Orpheus⁸.

Orpheus was the poet and musician of Greek mythology. Animals were magically drawn to him when he played his music, mountains budged, rivers changed their course, and stones and trees shed tears. He fell in love with Euridyce and wished to marry her. On her way to the wedding, Euridyce was bitten by a snake, collapsed and died. Inconsolable, Orpheus decided to follow his beloved to the underworld, the realm of the dead, and bring her back. Using his poetry and music he persuaded the gods of the underworld to relent, but on one condition: he must not turn back and look at her face until both of them step over into the world of light. Orpheus could not resist and turned his eyes to her just as she crossed yet still lingering in the shade. At this moment Euridyce disappeared back into Hades, this time forever.

Unlike Oedipal Freud who focused on repressed libidinal and aggressive drives in the unconscious, Ferenczi, by "adopting" the concept of Orpha, embraces the myth of Orpheus; he sends Orpha, the feminine manifestation, to search for the abandoned infant, the orphan, to raise the dead frozen infantile psyche from the underworld. Reviving it requires a descent into the regions of deadness, despair and absolute helplessness.

The transition from Oedipus to Orpheus is paradigmatic: from unraveling the unconscious drives to the revival of dead parts. Orpha, moreover, adds a feminine aspect to Orpheus (the failed reviver) by donating to him compassion, empathy, and the capacity to take over mothering functions. The notion of Orpha epitomizes the amazing human ability to die psychically and nevertheless to go on living. Furthermore, as Winnicott postulates, "[there is] a belief in the possibility of a correction of the original failure represented by a latent capacity for regression" (Winnicott, 1954).

Yet Orpha needs the analyst to restore faith in her, faith in an analyst who fully believes that the lost parts exist and is willing to dedicate himself to their rescue, to listen to their call from the dead: an Orphic analyst.

WHAT IS AN ORPHIC ANALYST?

The analyst, states Ferenczi, should be aware that early traumatized patients cannot express themselves in fear of the other as a recurring aggressor. The analyst, being feared, should provide honest interest, care, and provision in order to enable regression, so that early traumatization can be experienced without dissociation.

Ferenczi writes:

I am prepared here for the objection whether it is really necessary first to lull the patient by over-indulgence into a delusion of unfounded security, in order to subject him later to a trauma which must be all the more painful. My excuse is that I did not intentionally bring about this process: it developed as the result of what I considered a legitimate attempt to strengthen freedom of association⁹. I have a certain respect for such spontaneous reactions, I therefore let them appear without hindrance, and I surmise that they manifest tendencies to reproduction which should not, in my opinion, be inhibited, but should be brought to full development before we try to master them (Ferenczi, 1931, pp. 138–139)

For this process to evolve in analysis, the analyst must, first and foremost, gain Orpha's trust and help her look after the dissociated injured parts. For that purpose, he needs to regard himself from her perspective and understand her survival functions (Smith 1999). A patient's Orpha, then, may help the analyst treat the injured parts, and let him know what to say and do in order to support the suffering self. Relating to it as resistance, will be a re-traumatizing imposition of the analyst's agenda which will only distance Orpha again. Orpha must be sure that the therapist accepts her protestations as well as her suggestions.

In his diary, Ferenczi describes how a patient told him to wrap an impenetrable envelope around the painful part of her psyche which was situated in her head, in order to protect it from collapse, "and when he would go, to please leave part of himself with her to guard her as a protecting spirit" (Ferenczi, 1932, May 12th, p. 107). She demanded that he put his psychic powers at the disposal of her own fragmented psyche by addressing her in a simple manner. It did not work when Ferenczi spoke to her without showing feeling. She was responsive only when he fulfilled her needs wholeheartedly. Recognition of the therapist's failure, that is, making his emotional absence present, allows for the patient's inner absence to become present and leads to its revival.

Such a pact with the therapist restores Orpha's willingness to make its appearance in the intersubjective field, and to guide the therapist to the dissociated parts. A compassionate and protective gaze of the analyst may gradually relieve the terror of annihilation, and dissolve Orpha's own fear of

the exposure of tenderness and its revival. Orphic self-preservation can then be diminished, allowing for regression to dependence on the analyst.

Such an approach by the therapist will be felt by the patient as a fear-dissolving love, which then arouses a need¹⁰ (Ferenczi, 1932, June 3rd, pp. 113–117) for effortless tenderness. Rather than a narcissistic response, this is to be recognized as the formerly frozen passive love for the primary object: to be loved by the other without having to adjust and react to him. This love is restored if fear of the other is diminished; thus, the opposite of love is not hate, but fear.

Yet the road is strewn with obstacles and each and every inappropriate move may impede the rescue effort or bring it to a halt. The patient's dissociated psyche yearns for authentic and vital connection, though dreading it, too (as in "fear of breakdown", Winnicott 1974). Like in the myth of Orpheus and Eurydice, Ferenczi warns that exposing the dissociated to the living gaze of the analyst may cause it to die yet another death. Recognizing his potential and concrete lethal impact is the only chance to avoid total renunciation of the hope to rise from psychic deadness. The Orphic analyst knows the tragic survival solution and its consequences. Unlike Orpheus, he takes responsibility for his deadly impact, and unlike Orpha, feels the anguish and unbearable psychic pain of the dead parts, contains it, and attempts to revive them in order to restore genuine intersubjective relations.

It is crucial to realize that the real relationship between patient and therapist constitutes the space in which initial trauma is enacted repeatedly, and, in Winnicott's terms, there is a withdrawal (Winnicott, 1955, 1965, 1987) from the therapist to self-holding. Ferenczi demanded that the therapist acknowledge the inevitability of being an aggressor himself, the actual undertaker (Ferenczi, 1932, March 8th, pp. 51–53) of the patient's psyche, whether as a result of misunderstandings, due to the imposition of his interpretations on the patient, or because of the expectation that the patient adjust to the setting. The therapist should be aware how and when the patient feels imposed upon, or used, by the analyst for his own needs.

...the willingness on our part to admit our mistakes and the honest endeavor to avoid them in future, all these go to create in the patient a confidence in the analyst. It is this confidence that establishes the contrast between the present and the unbearable traumatogenic past, the contrast which is absolutely necessary for the patient in order to enable him to re-experience the past no longer as hallucinatory reproduction but as an objective memory (Ferenczi, 1933, p. 160).

Similarly, Winnicott states:

The treatment and management of this case has called on everything that I possess as a human being as a psycho-analyst, and as a pediatrician. I have had to make personal growth in the course of this treatment which was painful and which I would gladly have avoided. In particular I have had to learn to examine my own technique whenever difficulties arose, and it has always turned out in the dozen or so resistance phases that the cause was in a counter-transference phenomenon which necessitated further self-analysis in the analyst (Winnicott, 1954, p. 280).

The analyst must actively seek situations in which the patient adjusts himself to him by self-denial. It is the therapist's task to express and verbalize those clamoring, dissociated feelings on behalf of the patient, until he can express them himself. In doing so, the analyst recognizes his absences and failures and their deadening actual influence on the patient in the present relations. Giving presence to these external and internal absences empathically is the heart of healing and reparation. Given the containing intersubjective space to experience self assertion (ruthlessness, in Winnicott's language), annihilation anxiety can be tolerated without recourse to fragmentation and dissociation.

Winnicott describes this in a similar way:

In the end the patient uses the analyst's failures, often quite small ones, perhaps maneuvered by the patient, or the patient produces delusional transference elements and we have to put up with being in a limited context misunderstood. The operative factor is that the patient now hates the analyst for the failure that originally came as an environmental factor, outside the infant's area of omnipotent control, but that is now staged in the transference. So in the end we succeed by failing—failing the patient's way. This is a long distance from the simple theory of cure by corrective experience. In this way, regression can be in the service of the ego if it is met by the analyst, and turned into a new dependence in which the patient brings the bad external factor into the area of his or her omnipotent control (Winnicott, 1963, p. 258).

In drawing attention to the therapist's impact and his inevitable contribution to the repetition of the trauma in analysis, Ferenczi revealed the vulnerability and limitations of the therapist and made it necessary to acknowledge these as a vital part of the therapy. It is his attitude, his subjectivity, his counter-transference, that influences the transference, and not the other way around.

Identification with the Aggressor continuously terrorizes and curbs the needs for tenderness also from within. What is manifested in the intersubjective space (fear of the other) also reflects internal perverse relations (Steiner, 1993, pp.103–115) between parts of the self: the patient's

Orphic, double-faced functioning allows survival of the dissociated parts, but curbs their appearance both intra-psychically and intersubjectively in fear of breakdown. Trusting the analyst may allow the patient to recognize, revive, and contain not only his fear of the external perceived aggressor, but also of the violent domination of the “interjected” (Bollas, 1999, p. 113) one, that Orpha, by itself, cannot dissipate its threatening power.

Interpretation alone is never a sufficient tool to revive the traumatic events. “Something” (Ferenczi, 1932, Jan 31st, p. 24) must actually be added in the real relationship if it is to transform into a mental reality. When the therapist, together with and on behalf of the patient, experiences himself the deadness and suffering as real, he directs himself to the dissociated child, like an alarmed mother who comes to his aid, before the patient, will once again, identify with self-obliteration.

One must keep in mind that the fragmentation of consciousness is real. The damaged child is preserved in a primitive and primary way, responding to every other person as a threat to his psychic existence. The only way of connecting to him is by meeting him on the level of existence at which he became dissociated. In order to connect with him, the analyst must believe in his existence, feel him and address him directly:

*We talk a good deal in analysis of regressions into the infantile, but we do not really believe to what great extent we are right; we talk a lot about the splitting of the personality, but do not seem sufficiently to appreciate the depth of these splits [my emphasis]. If we keep up our cool, educational attitude even vis-à-vis an opisthotonic patient, we tear to shreds the last thread that connects him to us. The patient gone off into his trance is a *child indeed*, who no longer reacts to intellectual explanations, only perhaps to maternal friendliness; without it he feels lonely and abandoned in his greatest need, i.e. in the same unbearable situation which at one time led to a splitting of his mind and eventually to his illness; thus it is no wonder that the patient cannot but repeat now the symptom-formation exactly as he did at the time when his illness started (Ferenczi, 1933, p. 160).*

Play, tenderness, full trust in the realness of the patient’s experience, sincerity and authenticity—all these are critical for the revival of dissociated self states, and are “like a kind of glue, binds together permanently the intellectually assembled fragments, surrounding even the personality thus repaired with a new aura of vitality and optimism” (Ferenczi, 1932, March 20th, p. 65).

Yet again, the revival of insufferable psychic pain and of dissociated tender needs inevitably arouses ruptures in the therapeutic relationship itself. Experiencing helplessness allows for anger, rage at the analyst (Ferenczi, 1932, Feb. 2nd, pp. 28–29) to be felt and expressed. This should

be recognized as re-directing outward the aggression which was hitherto forbidden and turned against the self. The internalized aggressor now returns to his original place, to the other, and it is in the face of this other, if empathic, that the patient can now experience fear and helplessness, ensuing protest and anger.

This does not mean that the patient is destructive, but rather that his mental functioning is restored and revived, and so is the original ruthless self assertion. The initial expectation for the other to adapt to the self is alive again. The "I" exists and is capable of self reflection of the "me". It then becomes possible to pave a direct therapeutic path to the psychic pain which was stored in lonely, hidden isolation by the patient's Orpha.

In the process of reviving dead self states, the enactment of the initial traumatization also enfold in role reversal (Borgogno, 2008) and the analyst is actually being traumatized by the patient. Understanding it as such opens the way for the analyst to make use of it for healing the Identification with the Aggressor. Also, one meets expressions of what may seem mad in the patient. Yet every mad hallucination holds a grain of truth in it, which is related to the original confusing traumatic experience, now exposed in the intersubjective space. Trusting the analyst, this survival state reveals itself, in hope that the analyst will identify both what has been implanted by the outside and what is genuine and authentic (Ferenczi, 1932, March 3rd, pp. 46–48). In the present relationship with the analyst, protest, and "returning" to the analyst what belongs to him, now clear the confusion, establishing differentiation between internal and external reality.

This process lays a heavy burden on the analyst. It is unbearable for the analyst to be accused of "being a murderer" (Ferenczi, 1932, March 8th, pp. 51–53), yet it is inevitable that he will enact early trauma. But in contrast with the original "soul murder" (Shengold, 1989), the therapist must not deny his (analytical) guilt, not even for the fact that he cannot offer all the required maternal care, goodness and proximity, exposing his patients to the very dangers and psychic agonies from which they were saved by the skin of their teeth.

Once the therapist acknowledges that his deeds or his words have "committed murder" (Ferenczi, 1932, March 8th, p. 52), the patient is allowed to experience this through real psychic pain and to contain the terror of annihilation without dissociation and without defensive madness.

Resolving the fear of breakdown entails not only regression to dependence and trust, but mainly facilitating a growing capacity to contain its ruptures, while maintaining the safety of attachment. What has happened cannot be undone, but once absence is present and experienced, one can become reconciled with it, able to mourn it, and contain it without having to annihilate the self (Ferenczi, 1932, March 22nd, pp. 66–68). This is a

tedious and despairing process, but the Orphic analyst does not give up. He hears ghostly voices from the abyss, and believes in their existence, having faith in what is absent and dissociated, he descends into the crypt (Grotstein, 2010), striving repeatedly for their revival and lived presence.

Ferenczi and Winnicott are, in my view, Orphic analysts, who believe that there is life in deadness, and see it when it appears. They give clinical examples of their own but not as instructions; rather, they invite analysts to follow the idiosyncratic process of each patient with the analyst's own creativity and involvement according to the above guidelines. I will conclude with two extensive excerpts from Ferenczi and from Winnicott that speak for themselves. When juxtaposed, they reveal the incredible resemblance and complementarities in their theoretical and clinical ideas about regression to dependence in analysis. Both focus in the present and in the actual relations on the repetition compulsion of the deadening intrapsychic imprint of the initial early traumatic environment, and are immersed and involved in its revival in the present:

Ferenczi writes:

If, in the analytic situation, the patient feels wounded, disappointed or left in the lurch, he sometimes begins to play by himself like a lonely child. One definitely gets the impression that to be left deserted results in a dissociation of personality. Part of the person adopts the role of father or mother in relation to the rest, thereby undoing, as it were, the fact of being left deserted [this resonates with Winnicott's notion of withdrawal (1949, 1955, 1987)]. In this play separate bodily members—hands, fingers, feet, genitals, head, nose or eye—become representatives of the whole person, in relation to which all the vicissitudes of the subject's own tragedy are enacted and then worked out to a reconciliatory conclusion. It is noteworthy, however, that over and above this, we get glimpses into the processes of what I have called the "narcissistic cleavage of the self" in the mental sphere itself. One is astonished at the large amount of auto-symbolic self-perception or unconscious psychology revealed in the phantasy-productions of analysts, as, obviously, in those of children. I have been told little tales about a wicked animal which tries to destroy a jelly-fish by means of its teeth and claws, but cannot get at it because the jelly-fish with its suppleness eludes each jab and bite and then returns to its round shape. This story may be interpreted in two ways: on the one hand it expresses the passive resistance opposed by the patient to the attacks of his environment, and, on the other hand, it represents the dissociation of the self into a suffering, brutally destroyed part and a part which, as it were, knows everything but feels nothing. This primal process of repression is expressed even more clearly in phantasies and dreams, in which the head (i.e., the organ of thought) is cut off from the body and goes about on feet of its own, or is connected with the body only by a single thread (see a similar description in Winnicott, 1949). All this calls for interpretation not

only in terms of the patient's history, but also of auto-symbolism (i.e., as relations between parts of the self) (Ferenczi, 1931, p. 135).

Winnicott describes a similar view:

A young woman patient had to wait for a few months before I could start, and then I could see her only once a week; then I gave her daily sessions just when I was due to go abroad for a month. The reaction to the analysis was positive and developments were rapid, and I found this independent young woman becoming, in her dreams, extremely dependent. In one dream she had a tortoise, but its shell was soft so that the animal was unprotected and would therefore certainly suffer. So in the dream she killed the tortoise to save it the intolerable pain that was coming to it. This was herself and indicated a suicide tendency, and it was to cure this tendency that she had come for treatment.

The trouble was that she had not yet had time in her analysis to deal with reactions to my going away, and so she had this suicidal dream, and clinically she became physically ill, though in an obscure way. Before I went I just had time, but only just, to enable her to feel a connexion between the physical reaction and my going away. My going away reenacted a traumatic episode or series of episodes of her own babyhood. It was in one language as if I were holding her and then became preoccupied with some other matter so that she felt annihilated. This was her word for it. By killing herself she would gain control over being annihilated while dependent and vulnerable. In her healthy self and body, with all her strong urge to live, she has carried all her life the memory of having at some time had a total urge to die; and now the physical illness came as a localization in a bodily organ of this total urge to die. She felt helpless about this until I was able to interpret to her what was happening, whereupon she felt relief, and became able to let me go. Incidentally her physical illness became less of a threat and started to heal, partly of course because it was receiving appropriate treatment (Winnicott, 1963, pp. 249–250).

NOTES

1. Hayuta Gurevich, M.A. holds masters degrees in Clinical Psychology, Sociology and Anthropology. She is a Training Analyst and faculty member of the Israeli Psychoanalytic Association; member and faculty of the Winnicott Center in Tel-Aviv; and member and faculty of Primary Mental States, the Psychotherapy School affiliated with Tel-Aviv University. She lectures widely on early trauma and its intrapsychic impact, specifically dissociation. Her publications reflect her researches of the later writings of Ferenczi and their connections to Winnicott, contemporary theoretical frameworks and the clinical implications of enactments. She is in private practice in Tel Aviv.
2. As Rudnystky (1991) wrote: Winnicott's lack of recognition of those who came before him, in pursuit of his commitment to his own inner development exacted a human toll on

Ferenczi's followers, particularly on Michael Balint. To his credit—after Balint reminded Winnicott several times of the painful consequences of his evasive statements about the similarities between his work and that of others—Winnicott wrote: “I have realized more and more as time went on what a tremendous lot I have lost from not properly correlating my work with the work of others. It's not only annoying to people but it's rude and it has meant that what I've said has been isolated and people have to do a lot of work to get at it. It happens to be my temperament, and it's a big fault” (Rudnytsky, 1991, pp. 86–87).

3. Winnicott uses the concept of dissociation to refer to what has been experienced as deprivation and fragmented by traumatic environmental failure. It is not always clear if what is then dissociated is included in the True Self or not. He differentiates it from the more initial traumatic states that occur but are not experienced, as there is not yet a self to experience it, and do not allow for a True Self to be (see Papadima, 2006). I use this concept (Gurevich, 2008, 2014) in a wider sense to indicate a survival and automatic response to a fearful external threat that fragments the psyche so that psychic states are dissociated from each other.
4. Similarly, Ferenczi writes: the “content of the split-off ego—the tendency to complete the action interrupted by the shock... [is] limited to a tendency to repeat until it finds a better solution” (Ferenczi, 1932, Jan. 24).
5. I have discussed the concepts of Orpha, Orphic functions and Orphic analyst in Gurevich (2015).
6. This concept was referred to by Frankel (1998), Galdi (1999), Fortune (2003), Kalshed (2003), and recently received an extended significance by Haynal (2014) in his last conclusive article about Ferenczi. I join his deep appreciation for the late Nancy Smith (1998a, b, 1999, 2001) for her inspiring papers about Orphic functions.
7. Ferenczi usually used the concepts of repression and splitting and not the concept of dissociation, but uses them in the sense of dissociation—as an intra-psycho automatic survival reaction to external threat that fragments consciousness, keeping its fragments dissociated from each other.
8. Jacob Bryant, A British scholar and mythographer, who lived in the 18th century, described Orpha: “As there was an Orpheus in Thrace, so there appears to have been an Orpha in Laconia, of whose history we have but few remains. They represent her as a Nymph, the daughter of Dion, and greatly beloved by Dionusus. She was said, at the close of her life, to have been changed to a tree. The fable probably relates to the Dionusiaca, and other Orphic rites, which had been in early times introduced into the part of the world above mentioned, where they were celebrated at a place called Orpha. But the rites grew into disuse, and the history of the place became obsolete: hence Orpha has been converted to a nymph, favoured of the God there worshipped; and was afterwards supposed to have been changed to one of the trees, which grew within its precincts” (Bryant, 1774–1776, p. 136).
9. It is interesting to note that Michael Balint said in a paper that he read before the Memorial meeting of the Hungarian Psycho-Analytic Association, on October 3, 1933, (cited in Keve, 2012 p. 16) that Ferenczi took upon himself the new task of teaching the patients to be able to associate *really* freely (my emphasis).
10. Winnicott distinguishes wishes from needs: With the regressed patient the word wish is incorrect; instead we use the word need. If a regressed patient needs quiet, then without it nothing can be done at all. If the need is not met the result is not anger, only a reproduction of the environmental failure which stopped the process of self-growth.

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