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Winnicott's theory of maturation as a guide to clinical practice

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Abstract: Based on Winnicott's notion that the nature of maturational disorders is related to their point of origin within the maturational process, this study aims to show that the theory of personal maturation can be used as a theoretical horizon for clinical diagnoses and as guidance for clinical work. Initially, the fundamental assumptions upon which the theory is grounded, as well as its main characteristics, are discussed. We then offer an overview of the simplest classification normally used by Winnicott, one that includes psychoses, depressions and neuroses. Lastly, by way of example, we show that, in terms of symptoms, one same disorder (in this case, paranoia) can have different natures, depending on the moment of the maturational process when an environmental failure upset the individual's life.
Keywords: Winnicott, maturation, diagnosis, classification, paranoia.

1. Introduction

There are many ways to address the novelty of D. W. Winnicott's psychoanalysis. One is the clinical practice that derives from his innovative theoretical perspective. Whereas in traditional psychoanalysis there is a method that fittingly characterizes the task of analysis – interpretating unconscious conflicts related to censured and repressed material – the same cannot be said of Winnicottian clinical practice.[1] Although it is perfectly possible to explicate the clinical implications of his theory, one cannot formulate, in one general statement, a method or a technique that might define how one should work. The reason is quite simple: what determines the work to be done – and how a certain treatment should be conducted – are the *needs* of the patients, which can vary enormously depending on the nature of their disorder. We know, from now-classic Winnicottian texts, that what is beneficial for a neurotic or even depressed patient, for instance, can be quite useless or even harmful for patients whose central problem is psychotic, or for those who are antisocial. The psychic disorders can be of a radically different nature, as with the two pairs of afflictions mentioned above: while neurosis and depression denote unconscious conflict related to repressed material and occur in individuals whose personalities were well founded in early life but who at a certain moment became ill when having to deal with anxiety resulting from instinctual urgencies, psychoses, as well as

[1] In traditional psychoanalysis, the existence of a single psychoanalytical method is possible because it sees psychic disorders ultimately resulting in instinctual conflicts of an Oedipus or pre-Oedipus character. For a fuller insight into the use of interpretation in Winnicott, see Dias (2023).

antisocial tendencies, derive from an environmental failure to support the continuity of being and, thus, also the maturational processes in the most primitive stages in which dependence prevails. These disorders point to failures in the structuring of one's personality (the psychoses) or character (the antisocial tendency).

Because there are crucial differences in the nature of the disorders and, therefore, between what is required to treat each one, Winnicott emphasizes the essential importance of diagnosis as a guide to therapeutic action.[2]

> The essential thing is that I do base my work on diagnosis. I continue to make a diagnosis of the individual and a social diagnosis as I go along, and I do definitely work according to diagnosis.[3] In this sense I do psycho-analysis when the diagnosis is that this individual, in his or her environment, wants [traditional] psycho-analysis. I might even try to set going an unconscious co-operation, when conscious wish for analysis is absent. But by and large, analysis is for those who want it, need it, and can take it. (1962a/1962, p. 169)

In another article, from 1968, he also says that, "if we were better at diagnosis we would save ourselves and patients a lot of time and despair" (1968/1989, p. 234).

There are additional problems when clinical practice is guided by the theory of maturation, because the needs of a patient may vary within a session, inasmuch as he or she, although suffering from a sick aspect of their personality, also has healthy aspects. The analyst must deal with both simultaneously, attentive to the fact that, *if there is a sick aspect, it is as sick as it can be,* and one mustn't slacken one's attention, thinking it's possible to count on the developed part of the personality. Moreover, if the analysis goes well and the patient matures, the necessities will vary throughout the treatment, and the analyst needs to be prepared to recognize and deal with all of the aspects and phases of maturation, from the most developed to the most primitive ones.

Not only can we not speak of one particular technique in Winnicott, we cannot even understand analytical work, as conceived by Winnicott, as a technique. Formulating his notion

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[2] Although the question of diagnosis has been central to psychoanalysis since the 1930s and 40s, the reasons were different from the one later emphasized by Winnicott: at that time, it was a matter of identifying the purported "well-chosen cases," since for Freud and Anna Freud psychoanalysis was applicable only to neuroses, not to psychoses. It was Melanie Klein, by analyzing young children, who introduced the idea that psychoses might also be treated by the psychoanalytic method. From Winnicott's perspective, therefore, Freud and Anna Freud, who naturally thought and practiced psychoanalysis in its traditional formulation, were right to say that psychoanalysis pertains only the neuroses. But, for the English psychoanalyst, Klein was also right to include psychoses in psychoanalytic treatment, with the proviso that including them required a profound revision of the theoretical foundations and an essential modification of the etiology and, thus, of the psychoanalytic methods and technique.

[3] Winnicott uses here the term "social" to mean "familial." This meaning is corroborated in "Do progressive schools give too much freedom to the child?" (195b/1984), item "Classification A".

of the therapeutic task in the introduction to *Therapeutic Consultations in Child Psychiatry* (1971b), Winnicott states that the therapeutic task described therein can hardly be understood as a technique, as no two cases are the same; the work cannot even be copied because, as he asserts, "the therapist is involved in every case as a person, and therefore no two interviews could be alike as they would be carried through by two psychiatrists" (1971b, p. 9)

2. The theory of maturation as a guide to therapeutic action

Winnicottian clinical practice is based on a theory of psychic disorders that is itself based on the theory of the personal maturation process of the individual. This theory, according to Winnicott himself, is the "backbone" of his theoretical and clinical work.[4] He explicitly traces the intimate connections between the theory of psychic disorders and the theory of maturation, and says: "We do need to try to get at a theory of normal growth so as to be able to understand illness and the various immaturities, since we are now no longer contented unless we can cure and prevent" (1962b/1965, p. 67).

The theory is based on a few concepts that can be briefly presented as follows:

Every human individual is endowed with an innate tendency towards maturation, that is, towards integration into a unity. Although innate, however, the tendency does not go it alone, as if the mere passage of time were enough. It is a tendency, not a determination. For the tendency to be actualized, the baby depends fundamentally on the presence of a facilitating environment that provides good enough care. This is all the more true, the more primitive the stage we consider.

The maturational process begins at some point after conception and, in health, doesn't cease until death.

The entirety of Winnicott's work is thought of in terms of health or sickness. Health is a complex state, with its own demands, and must be thought of in itself, unlike the concept of health in psychiatry, and even in psychoanalysis, that conceives it as the mere absence of disease – a notion Winnicott deems highly insufficient. For this reason, in his theory he points to the difficulties that exist in the very fact that we are alive and maturing. This concept of health is present throughout his thought and has greater implications than can be seen at first sight, namely, that from the very beginning, *life is difficult in itself* and the task of living, staying alive and maturing is an ongoing struggle.

[4] He also states numerous times throughout his work that the theory of maturation is central to his thought, and clearly uses the decisive expression "*backbone*" in text "Freedom", (1969/1986, p. 236).

In health, maturation continues and the creative impulse is preserved. Thus, life is felt as worth living, despite all the troubles and suffering.

Disease is fundamentally immaturity. The gravest immaturity is not having been able to integrate into a self.

There is no aspect of human existence, in health or in sickness, whose meaning is independent of the moment of the process to which it belongs or from which it originated, since the Winnicottian classification of emotional disorders is primarily maturational and only secondarily symptomatological. For instance, we cannot answer the question of what aggression means in Winnicott without defining the stage to which we are referring.

Having conceived health as continuing maturation, with the satisfactory resolution of different, successive tasks, Winnicott was able to understand psychic disorder, or more properly, maturational disorder, as an interruption or a distortion of this process due to lack of environmental facilitation. The nature of the disturbances varies according to the stage at which the trouble set in. Of course, this provides the therapist with a mapping of the etiology of each disorder.

3. The theory of maturation

In what does the theory of maturation consist? In the description and conceptualization of the different tasks, achievements and difficulties inherent to the growth in each stage of life, from the moment when a state of being starts, still in the womb, extending through infancy, adolescence, youth, adulthood, old age and, finally, death. The emphasis of the theory is on the initial stages, because it is in this period that the foundations of the personality and those of psychic health are being built. The tasks that characterize the initial stages –integration in time and space, indwelling of the psyche in the body, onset of object relations and constitution of the unit self – are never completed and continue to be the fundamental tasks throughout life. These tasks are not instinctual in nature – as some will be a little later on – and belong to what might be called identity or relational line of maturation, i.e., they pertain to the need to exist, to feel oneself real and to establish oneself as a unitary identity, and include the ability to relate to the world and to external objects, and to establish interpersonal relationships.

Although the maturational process is not linear, certain achievements have prerequisites and can only be attained after others have set up the conditions that make them possible. That is, the satisfactory completion of the tasks of each stage depends on the successful resolution of the tasks of the previous ones. If the task of a certain stage is not concluded, new tasks will

nevertheless continue to arise, yet the individual, not having completed the previous achievement, will lack the necessary maturity to face them. He or she may even resolve them by mobilizing the mind and/or a defensive and counterfeit integration of the "false self" type; however, being founded on false bases, they will not become an intrinsic part of the self as a personal achievement. In these cases, the process of personal maturation is paralyzed and a maturational disorder sets in.

4. Criteria for a classification of maturational disorders

According to Winnicott's theory of maturational disorders, the nature of a disorder is related to the stage, in the line of maturation, in which the trouble arose; in other words, it is related to the state of immaturity or relative maturity in which the baby or child found itself and to the nature of the task in which it was involved when the environmental failure occurred. The type of disorder also has to do with the type of environmental failure – maternal or paternal – responsible for the traumatizing environmental pattern. This brings us to the following requirement for diagnosis: whatever the phenomenon we wish to consider, in illness or in health, it can only be properly appraised if we take into account the individual's entire maturational process, from the most primitive stages, and are able to locate the stage in which the phenomenon originated. "One of the difficulties of our psycho-analytic technique is to know at any one moment how old a patient is in the transference relationship" (1949a/1958, p.181). Only then can we comprehend the nature of the trouble that afflicts the individual, proceed to a classification of the disorder and provide the specific care in accordance with his or her needs. It is necessary to "always think in terms of the *developing individual*. This means going back very early and looking to see if the point of origin can be determined" (1960a/1986, p. 81).

In broad strokes, one could say that, according to Winnicott, *psychoses* are disorders related to the failure of the environment in facilitating the achievements of the early stages – which start at some point still in the womb and reach up to the I AM stage, when the young individual achieves a more stable integration, that is, a unitary identity. This generally takes place around the child's first year or year and a half. If the environment fails repeatedly – in such a way that a pattern is established – in adapting to the needs of the baby during the stage of absolute (or even relative) dependence, traumas will occur – the unthinkable agonies – and the personal maturation process will be interrupted in this primitive moment when the foundations of the personality are still being built. Primitive defense mechanisms are then organized, *and this is what a psychotic disorder is*. Naturally, there will be different types of

psychotic disorders depending on the moment the baby is traumatized by environmental failures (within the initial stages of absolute dependence and the onset of relative dependence) and on the type of environmental failure that produced the trauma.

Once a unitary identity is achieved (in the maturational landmark of the I AM stage), the child, who is now between one and two years old, will have to become concerned and take responsibility for results, in Winnicott's words, and face the task of integrating its instinctual impulsiveness in the other – in the mother, in this case, because the child's relative maturity only allows for a dual, or two-body, relationship. This is the central task in the long-lasting stage of concern, which begins after the achievement of the I AM – because only by becoming a self can the individual feel responsible for something, for acts and thoughts — and is never completed before the age of five. (It might be said that it peaks around the age of two and a half.) With this achievement, which is established slowly, the child ceases being ruthless and becomes concerned, which means that it acquires the capacity to feel guilt and to take responsibility for the results of its now-personal instinctual behavior – and must fix (or, in Winnicott's words, *mend*) the damage or holes it imagines it has caused in the mother's "body of richness". When the environment favors this achievement, the child appropriates, without much fright or alarm, the destructiveness that pertains to its own nature, and thus, in a healthy and natural manner, becomes capable of depressing each time destructiveness manifests itself and places the relationship with a loved one at risk. Winnicott calls the depression that results from this situation "reactive depression," which is very different (perhaps not in symptomatology, but surely in the etiology and the nature of suffering) from depressions of psychotic origin. He says:

> The depressions that are encountered clinically in psychiatry are chiefly not of the type that is related to the "depressive position." They are more associated with depersonalization, or hopelessness in respect of object relationships; or with a sense of futility that results from the development of a false self. These phenomena belong to the era before that of the depressive position in the individual's development. (1954/1958, pp. 271-72)[5]

[5] Melanie Klein's concept of "depressive position" is, according to Winnicott, her greatest contribution to psychoanalysis. Maintaining the central points of the Kleinian concept, he reformulated it according to his own understanding of human nature and maturation, and renamed it "stage of concern." However, he often refers to this achievement with the expression "depressive position," already enshrined in the psychoanalytic universe, especially in lectures he gave at the British Psycho-Analytic Society, although, in his words, "the term 'depressive position' is a bad name for a normal process, but no one has been able to find a better. My own suggestion was that it should be called 'the Stage of Concern'." (1954/1958, p. 264)

If, at this moment, the mother fails in her specific tasks of surviving the impulsive attacks of the child, and of recognizing and accepting the restitutive gesture (that would allow a "benign circle" – to hurt and to heal – to be established), there will be the risk of *pathological depression*, as the child will not know what to do with the guilt from seeing itself destroy that what it most needs and whom it most loves.[6]

In favorable cases, when the capacity for concern is achieved, the child, who was thus able to consolidate the foundation of its personality, will have to deal with the anxieties that arise from its relationships with other people, perceived as external. In particular, it will have to face the conflict involving issues of loyalty and disloyalty towards its parents, which prepares it for the triangular (three-body) situation where the Oedipus complex can be effectively experienced among *whole persons*[7]. The anxieties thus mobilized pertain to the instinctual life – that is, to the management of excited states, which already include genitality, amidst interpersonal relationships – and to the feelings and fantasies that have a place in one's personal psychic reality, where they give rise to a range of internal tales.

In this stage, the environment no longer has the type of importance it had in previous ones, but it is vital that it remains stable enough to provide good conditions, so that the child, unworried with the safeness of its home – which will look after itself –, can face and organize its personal inner situation and not succumb to a neurosis.

One of the most relevant issues in Winnicottian clinical practice is that, in the analysis of any type of patient, as the work advances and trust is established, one cannot ever exclude, in principle, the possibility of a psychosis arising, or of psychotic elements emerging, because, as Winnicott says, "in any one case it may be found that there is a psychotic illness under everything" (1988, p. 164). If there is an underlying psychosis, it can appear during analysis precisely because of the reliability of the environment, since the individual who bears an unthinkable agony has to fall ill, and will indeed fall ill, if he or she finds an environment conducive to treatment. This is what Winnicott calls regression to dependence. To those

[6] The risks of poorly resolving the task in the stage of concern are the inhibition of the instinctual impulses, which can be severe, or pathological reactive depression, although not the interruption of the maturational process (which is peculiar to psychoses), as Jan Abram states, in the summary of the item "Depression," in *The Language of Winnicott* (Abram, 2007, p. 148).

[7] For Winnicott, the individual only becomes a whole person when, after being integrated into a unitary identity, into an 'I', one also integrates instinctual life and the destructiveness it contains. That is, integration into an 'I' is still not enough; one must integrate the consequences of being alive and having appetites, and the ability to take the other into account as a person. Regarding Oedipus, Winnicott states, "I cannot see value in the use of the term Oedipus Complex where one or more of the trio is a part object. In the Oedipus Complex, for me at least, each of the three of the triangle is a whole person, not only for the observer but also and especially for the child." (1988, p. 49).

analysts who say they have absolutely no interest in psychotic cases, Winnicott responds with his own experience:

> My clinical experience of adult cases must be assumed to be that of a psychoanalyst who, whether he likes it or not, becomes involved in the treatment of borderline patients, and those who perhaps unexpectedly become schizoid during treatment. (1967/1989, p. 193)

For all this, Winnicott trenchantly asserts that the psychoanalytic theory originally formulated to understand neurosis, is insufficient to understand and treat psychotic pathologies or the episodes of a psychotic nature that arise during analytical treatment. He also says that, not only himself, but other psychoanalysts have also been drawing attention "to the inapplicability of the so-called classical psycho-analytical technique to the treatment of schizophrenia," (1964b/1989, p. 492) referring to the fact that traditional theory used, for the study of psychoses, the same conceptual elements that had been used for neuroses, unaware of the essential difference between these two types of disorder. In pure neurosis, if we can still presume this, the structure of the personality is intact and the patient becomes ill through dealing with those difficulties inherent to instinctual life in the framework of interpersonal relationships. In psychoses, the maturational process is paralyzed at a certain moment in the initial stages, due to a traumatic environmental pattern. The baby, having to systematically react to the trauma, loses its spontaneity, hope and the ability to rest. A defensive split takes place within. The true self, which is spontaneous and creative, is isolated and protected from the threat of annihilation by a false self posing as the real person. It is this false self that presents itself to the world as an "I", even if it is no more than a prosthesis, and carries out the task of integrating itself into a unity and of relating itself with the external reality. This integration, however, remains external, operated from outside by impersonal elements from the environment; spontaneity has been buried and is out of reach.

Such are the cases of individuals who, although highly competent and successful in their specific fields, complain about a permanent lack of meaning, and of feeling deep within themselves that life is not worth it. They sense they are a fraud, a sham. The fact is that despite having acquired the ability to deal with the demands of a shared reality, their initial experiences were so deficient or distorted that the analyst will probably be the first person in their life to provide those things that are simple yet essential, namely, the opportunity to live out primitive experiences in an environment that, this time, will fulfill the specific needs of the moment. In the case of psychotic pathologies, if one wants to get to the root of the patient's problem,

regression to dependence is necessary. This assertion is based on the need of the patient and *not* of the theory or of what might arguably be a Winnicottian "technique."

5. The possible different natures of one same symptomatology according to the theory of maturation

I must stress once again that the Winnicottian classification of psychic disorders hinges on maturational, not symptomatological, criteria – disorders with very similar symptoms can be of a different nature, depending on their point of origin in the initial line of maturation and the type of environmental failure that caused them. As an example, which could be any other, I will mention different clinical phenomena of persecutory anxiety. For Winnicott, paranoid disorders, in themselves, do not constitute a nosological category, but are always a complication – making prognosis overall more negative – either of schizophrenia, antisocial tendency or depression. Because they have different natures, these paranoid perturbations require different therapeutic approaches.

When the disorder is an aspect of schizophrenia, one can suppose that susceptibility to persecution was instated very early. Indeed, it is possible to find a paranoid disposition even in very young babies. The primitiveness of the phenomenon led some investigators, especially those of the Kleinian school, to attribute the disorder to the constitutional factor. However, we do not need the constitutional hypothesis if, in face of early manifestations of paranoid anxiety, we take into account two facts: 1) That every baby has a pre-history – the life in the womb, the birth and the period immediately after birth, and 2) That the baby's dependence is greatest and most significant when the state of being has begun and during the first months of life, *which is extremely important to appreciate primitive persecutory disorders.* When one talks of good enough care, one is talking of a reliable environment, and this means, above all, protecting the baby from unpredictable events, fright and discontinuities that traumatize.

I list below some of the different points of origin of paranoia, with no intention of exhausting the subject, of course:

1. A primitive paranoid disposition might derive from a traumatic experience at birth. Unlike Klein, for whom the etiology of paranoid anxiety basically derives from oral sadism and ambivalence, for Winnicott a primitive paranoid disposition may derive from a traumatic birth experience. From his perspective, birth is not traumatic in itself, but becomes traumatic if difficulties arise that delay or precipitate it. The entire process of birth is, of course, a discontinuity, but if all goes well it does not exceed the level of what is tolerable for the baby.

If, however, parturition is unduly protracted or is anticipated, the baby will be exposed to a more prolonged discontinuity than it might be able to withstand (cf. 1949a/1958, p. 190). This imprints "a pattern on the infant of expected interference with basic 'being'" (1949a/1958, pp. 190-191) and may, therefore, induce a paranoid disposition.

> My suggestion, which is based on psychoanalytic work, is that in certain cases in which the history [of the paranoia] goes back to birth, there is so strong a predisposition to ideas of persecution (as well as a set pattern for persecution) that probably the paranoia in such a case is not consequent on oral sadism. In other words, in my opinion there are certain cases of latent paranoia in which the analysis of the paranoia along the lines of recovering the full extent of the oral sadism does not bring about the complete resolution because there is needed in addition a reliving of the traumatic birth experience in the analytic setting. (1949a/1958, p. 190)

2. Another origin for an early paranoid disposition, perhaps the most frequent one, is the pattern of the mother who finds it difficult or impossible to make personal contact with her baby, and/or the pattern of environmental unpredictability after birth whereby the mother, often because of her own psychopathology, is not able to offer the baby a continued sense of protection. Environmental invasions generate immediate reactions in the baby, and these are traumatic, as they interrupt the continuity of being at a very early stage in life.

> The infant that is disturbed by being forced to react is disturbed out of a state of "being". This state of "being" can obtain only under certain conditions. *When reacting, an infant is not "being"*. (1949a/1958, p. 185; italics mine)

In another text, Winnicott confirms this same point:

> The alternative to being is reacting, and reacting interrupts being and annihilates. Being and annihilation are the two alternatives. The holding environment therefore has as its main function the reduction to a minimum of impingements to which the infant must react with resultant annihilation of personal being. (1960b/1965, p. 47)

In these cases, the baby, instead of simply continuing to be, calm and relaxed, is gripped by a state of alertness that prevents it from resting. What happens, then, is an interruption in the continuity of being. If this state becomes a pattern, the maturational process is paralyzed: a split occurs, as a vital part of a primitive defense system that aims to prevent the now-potential invasion. It is this state of affairs, according to Winnicott, that characterizes schizophrenic pathologies. "The word illness," he says, "becomes appropriate through the fact that in many

cases the *sense of security did not come into the child's life early enough to be incorporated into his beliefs.*" (1946/1984, p. 117; italics mine)

3. A different source of paranoia, also primitive, derives from the lack of prompt response to instinctual tensions, from the discomfort that the unsupported baby remains at the mercy of. To be more precise: before the psyche dwells in the body, instinctual tensions are as intrusive as any environmental impingement, and to prevent these tensions from interrupting the continuity of being, the baby needs active facilitation from the mother to resolve the excitement that arose. We must bear in mind that for an invasion to occur, the environment does not have to be actively invasive; it will be invasive enough just by not being facilitating. When the mother promptly tends to the instinctual urgency, what she prevents is not yet a frustration, but rather the *interruption of the continuity of being*, because, according to Winnicott, "instinctual demands can be fierce and frightening, and at first can seem to the infant like threats to existence." (1949b/1964, pp. 80-81) If the mother, when tending to the instinctual urgency, is also able to give support to the ego and provide global experiences (including mutuality and communication), the whole process initiated by the instinctual tension becomes an experience that strengthens the ego and favors the child's psychosomatic cohesion. Without this support, however, the instinctual tensions, even if satiated, instead of becoming gradually integrated and personalized, remain external; over time, they may become persecutory – because hunger is as disturbing as thunder – and eventually establish a paranoid disposition, which could take the form of hypochondria, for instance, due to the permanent threat of depersonalization.

4. Another very primitive source of paranoia may occur when the baby's creative impulse – its spontaneous gesture – is inhibited, together with the ensuing motility. Some mothers are willing to nurse their children but don't appreciate all the movement, voraciousness and vivacity typical of excited states, and suppress or restrain them. With this, the personal and creative impulse of the baby and its excitement is inhibited, so that its movements are no longer impulsive, but merely reactive to invasions. At this point, a pattern of reactiveness can be established in the individual whereby all spontaneity is buried; there is no more reaching out and no more personal impulsiveness. The baby continues to live, says Winnicott, "because of being seduced into erotic experience; but separately from the erotic life, which never feels real, is a purely aggressive reactive life, dependent on the experience of opposition" (1950/1958, p. 217). This unfavorable situation is at the origin of one of the forms of paranoia; the child is always seeking out invasions and, later, also the persecution that will ignite movements,

because it only experiences something by reacting to it. To feel itself alive, it requires continual persecution.[8]

5. A somewhat later origin of paranoid anxiety, but still within the initial stages, is the moment when, after the period of absolute adaptation, the de-adaptation of the mother begins. There are cases in which the reliability of the environment, established during the period of absolute dependence, breaks down precisely when the separation of the mother-baby unit gets underway, and the first space between them, the potential space, begins to open up and be filled with transitional objects. Winnicott would say that at this point there is

> […] an alternative danger, which is that this potential space may become filled with what is injected into it from someone other than the baby. It seems that whatever is in this space that comes from someone else is persecutory material, and the baby has no means of rejecting it. (1966/1971, p. 120)

It is probably this same type of environmental failure, along with an early exploration of mental functions, that is at the origin of an extremely uncomfortable category of paranoia, which only appears in later stages and may affect people who manage to attain positions of authority or responsibility. These are individuals whose creative impulse was inhibited, as attested by their evident lack of contact with the ever-changing experience of life, when it is alive. It is equally likely that they did not go through the much-needed experience of omnipotence in early life, when the world – the subjective world, of course – is under one's control (for instance, the breast appears when hunger calls and vanishes when hunger ceases). Because they lack the sense of being able to create and transform the world, these individuals' defensive lives are *dominated by a system of thought* and strictly structured around this system; they are absolutely convinced – and this is never questioned – that living is only possible within a system that enables them to strictly separate good from evil. Overall, doubts are excluded from this system, because they generate unrest and movements that, dangerously, draw the individual towards life – unlike principles, which are dead things, says Winnicott. Moreover, in this type of paranoia, the individual and those around him/her are the only chosen ones always on the side of truth: "This system must be constantly shown to explain everything, the alternative (for the individual ill that way) being acute confusion of ideas, a sense of chaos, and a loss of all predictability" (1971c/1964, p. 164)

[8] For a deeper understanding of this point, see items II and III of Winnicott's text, "Aggression in Relation to Emotional/ Development", (1950/1958) chapter XVI of *Through Pediatrics to Psychoanalysis*.

6. Yet another type of paranoid disposition, entirely different from all the former, is a temporary feeling of persecution, which is part of normal maturation, related to the acquisition of the status of unitary identity. The acquisition of the status of I AM is felt by the child as a challenge, since the separation of the "me" as a unitary identity implies the rejection of all that is "not-me" and the recently integrated individual now awaits the retaliatory persecution of the repudiated external reality. This is a difficult passage for the child, says Winnicott, because it feels "infinitely exposed"; if the child is not properly protected by the environment at this moment, the susceptibility to persecution, which is fleeting in principle, can install itself as a paranoid characteristic of the personality.

7. There is also a type of paranoia rooted on deprivation and, therefore, associated with antisocial tendency. Winnicott uses the term "deprivation" for the outcomes of environmental failures that occur after the achievement of the I AM and are, therefore, already perceived as failures by the child. A "deprived" individual is someone who enjoyed a good beginning, who trusted the reliability of the environment, who felt "able to count on…," and suddenly lost that which he or she once could rely on. This imparts a kind of "credit" on the individual, who is thereafter led to constantly seek indemnification. Or is driven to a kind of paranoia in which he or she can never trust anything good will last. One of Winnicott's patient, 16-year-old Sarah,[9] was a troubled teenager who systematically destroyed her good relationships. She had dreams of being chased, and sometimes, even in her waking hours, felt as if she might be stabbed in the back. During a therapeutic interview, Winnicott reconstructed, with the help of the squiggle game, a disillusionment she had suffered, around 1 year and 9 months old, when her mother, six months pregnant with her brother, could no longer carry her, and changed from being a particularly good mother to a not-so-good one. That was the pattern of her paranoia: if she found something very good, the very goodness of it would always change at some point, and she would therefore lose it. To avoid feeling the loss, she would hate it and destroy it beforehand.

8. Another source of paranoia, pertaining to the instinctual line of maturation, is associated with anxiety toward the intrinsically destructive aspect of the impulsive instincts. This paranoia originates later – and is, therefore, of a different nature – because the child, who now "is", begins to feel concerned and responsible for the results of its own impulsiveness. Various modes must be taken into consideration here. In one of them, the entire line of aggression, from the very roots, is impaired; this happens, for instance, when the mother does not tolerate the baby's excited states and its impulses are eventually inhibited. Not being able

[9] Sarah's case deserves to be read in full, given its numerous important and illuminating details. It is the first clinical case illustrating Chapter X of *Playing and Reality*.

to ruthlessly exercise its greedy primitive impulsiveness, the child is unable to deal with the task pertaining to the stage of concern, namely, integrating into its maturational process the destructiveness inherent in primitive instinctual life. Thus, its impulses are felt as invasive or persecutory, possibly bringing about, again, a hypochondriac state, which is the type of paranoia when persecution comes from within; it manifests itself by the constant fear that some spark of aggression might escape one's control and gain ground.

A second form of this same type of paranoia, related to instinctual impulsiveness, involves the now-established existence of internal persecutors – the so-called bad objects, i.e., those that were incorporated during unsatisfactory or persecutory experiences. In these cases, the individual incites the external world in order to be persecuted by it and, thus, obtain relief from the internal persecution by avoiding excessive exposure to one's delusionary madness. There is a third mode, possibly the one most studied in traditional psychoanalysis, and which Winnicott also considered in terms of achieving the capacity for concern: it is the paranoia in which the individual is incapable of entering into an agreement with his or her personal destructiveness, perhaps for not having had a mother who reinforced the benign circle. In these cases, the individual solidly and systematically projects onto the world and onto others his or her destructive impulses, which naturally end up coming back in the form of persecutors.

6. Closing remarks

What I have put forward here is an attempt to present a sample of the diagnostic richness of Winnicott's theory of personal maturation when used as a guide to understand the phenomena of both health and psychic-maturational disorders. In the light of the theory of maturation, each disorder can be seen through this broad spectrum, which demands from analysts an attentive examination of the emotional and relational history of each patient, from the most primitive phases onward, to discern the point of origin of a particular distress. Without this theoretical background, it is not possible to make out the specific nature of the disorder.

With the above exercise on paranoia, I hope to have made it clear that the therapeutic endeavor should vary according to the specific root of the displayed paranoia. Bearing in mind that the first five modes of paranoia I mentioned refer to the primitive stages, prior to the integration of the self into a unit identity, clinical work should be pure management – adapted, of course, to each type of need that arises – so as to facilitate the requisite regression to dependence. The first mode, for instance, will also require "a reliving of the traumatic birth experience in the analytic setting" (1949a/1958, p. 190). With regard to the sixth mode, a natural

result of the achievement of I AM, the therapist must, for a short time, "be between the repudiated external world and the newly integrated individual" (1988, p. 121), because with this protection "the paranoid pattern need not become organized and the individual has the opportunity to develop a true instinctual impulse" (1988, p. 121). In the seventh mode, originating in deprivation, the question becomes one of interpretation – in a backdrop of management, of course – not in the traditional sense, but in a specifically Winnicottian sense of, as I wrote in another study,

> […] interweaving the nexuses between the current difficulties, impediments, inconsistencies and fears that imprison and torment the patient, as well as those of his or her initial environment, and the perhaps deficient way the world presented itself in early childhood. This probably not only prevented certain basic achievements, but also triggered and established defensive patterns of relating to the world and to others. (Dias, 2023, p. 95)

In the eighth item, regarding paranoia originating at a later point of maturation and already involving maturational achievements related to concern and to the mental mechanisms of projection and introjection, the interpretation of primitive greediness is now tenable (in the sense that perhaps it was not properly integrated when achieving the capacity for concern) – and likewise that of difficulty to achieve ambivalence. Equally feasible is the type of interpretation whereby the analyst clarifies to the patient his or her current state of maturation – not theoretically, but by means of phrases pointing, for instance, to unattained achievements: "It seems like you never experience this to the end, doesn't it? Perhaps you need that experience." Depending on the point of origin of the difficulty, this should be the position and the work assumed by the therapist. Winnicott is quite confident of the value of this theory for clinical practice:

> Gradually a highly complex theory of the emotional development of the human being has been worked out, so that with all our terrible and at the same time exciting ignorance, we now have useful working hypotheses, hypotheses, that is to say, that really work. There is now sufficient material available for attempts to be made to formulate things about infants which concern equally the psychiatrist and the children's physician, and I want to be one of those trying to say these things. (1948/1958, pp. 157-158)

Formulated in the light of his theory of maturation, Winnicott's psychopathology makes a fundamental contribution to psychoanalytic clinical practice by guiding diagnoses and providing a lodestar for therapists, who must always be aware of the patient's emotional age at any given moment of the analytical process, both to realize the immaturity exposed there, and

to accompany the patient in the different stages of maturation – including the phases of great dependence and even of growing independence. This horizon enables, in particular, the treatment of the so-called difficult cases, which traditional psychoanalysis is uncapable of. But that is not all; the theory also makes it possible to rethink therapeutic procedures in several other areas of healthcare – pediatrics, child psychiatry, speech therapy, nursing, occupational therapy –, can be used to ascertain what is required from social welfare and education in terms of care that abets maturation, and constitutes a precious contribution to all those involved in prevention policies.

Without this horizon, says Winnicott, we will be stumped in our work. This, undoubtedly, is also the meaning of his assertion that, "the only companion that I have in exploring the unknown territory of the new case is the theory that I carry around with me and that has become part of me and that I do not even have to think about in a deliberate way" (1971b, p. 6).

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