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Personal and Growable Settings in Winnicottian Clinical Practice[*]

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Abstract

In Winnicottian clinical practice, the therapeutic setting is very important, among other things, in the sense of an environment that facilitates the patient's tendency towards integration along the maturational process. It is important also because models for the Winnicottian settings derive from the many facilitating environments of the natural family, and these environments innately change, expand and become increasingly complex as the personal maturational process develops. The Winnicottian setting is personal and growable, like the facilitating environment, adapting itself at first, then gradually de-adapting to re-adapt to the patient's new developmental needs. A reliable setting is even more important in the case a regressive patient's need for dependence. A case fragment will illustrate how the setting reflects and relates to the patient's maturation.

Keywords: Settings, Winnicottian paradigm, personal adaptation, growable environments, maturational process, Winnicott's Wheel of Life, Winnicott's environmental theory, Regression to dependence.

1. Settings and Environments

In Winnicott's use of language, it is interesting to study carefully his choice of words and his intention. The topic we are discussing today is the *Setting* in the Winnicottian paradigm. This term comprises the articulation between natural environments and professional therapeutic settings in Winnicott's ideas.

The word *setting*, from the etymological viewpoint, as the verbal noun from *set*, means "fact or action of setting, putting, placing or planting (something)." In Middle English, it meant "act of creation." It was not until the nineteenth century that the meaning of *background*, *history*, *environment* was attested.

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Emphasis on the importance of the role of the environment is one characteristic of Winnicott's working theory, which always follows certain principles to gradually establish a unique theory of the human maturational process. Winnicott found that two things are essential in the maturational process: one is the innate tendency toward integration, and the other is the environment that facilitates the actualization of this tendency. He briefly described these working principles:

> The basic statement is that emotional development is a process of maturation to which is added growth based on the accumulation of experiences.
> The maturational process is that which is inherited.
> It does not become actual except in a facilitating environment.
> The facilitating environment needs to be studied in relation to the details of the maturational process. (1964/1989, pp. 100-101)

This theory is particularly important in Winnicott's work with borderline and psychotic cases. In his own words:

> To examine the theory of schizophrenia one must have a working theory of the emotional growth of the personality. […] What I must do is to assume the general theory of continuity, of an inborn tendency towards growth and personal evolution, and to the theory of mental illness as a hold-up in development. (1967a/1989, p. 194)

Winnicott's *general theory of continuity* embodies his theory of maturational process. If we think of *mental illness as a hold-up in development*, then our therapeutic work actually consists in removing the obstacles to the patient's maturational process. When an obstacle is removed, the powerful force of the person's inherent tendencies is enough to enable individuals to continue to grow.

In our work, borderline and psychotic patients need therapists to provide facilitating conditions. Often these two types of patients have not attained the maturity required to function as a whole person. When faced with the intrinsic difficulties of life, interpersonal relationship problems and inner emotional conflicts, their unstable personality structure is more susceptible to intrusion and impingement, and sometimes it even breaks down. Describing these two types of patients, Winnicott once said they differ from psychoneurotic patients and require different skills from therapists. In these patients,

> […] the wholeness of the personality only just begins to be something that can be taken for granted; in fact one can say that analysis has to do with the first events that belong to and inherently and immediately follow not only the achievement of wholeness but also the coming together of love and hate and the dawning recognition of dependence.

> This is the analysis of the stage of concern, or of what has come to be known as the "depressive position." These patients require the analysis of mood. […] nevertheless some new management problems do arise on account of the increased range of clinical material tackled. Important from our point of view here is the idea of the *survival of the analyst* as a dynamic factor. (1954/1958, p. 279)

There is a third category of more immature patients:

> […] I place all those patients whose analyses must deal with the early stages of emotional development before and up to the establishment of the personality as an entity, before the achievement of space-time unit status. The personal structure is not yet securely founded. In regard to this third grouping, the accent is more surely on management, and sometimes over long periods with these patients ordinary analytic work has to be in abeyance, management being the whole thing. (1954/1958, p. 279)

Winnicott then points out the importance of the environment for these patients:

> To recapitulate in terms of environment, one can say that in the first grouping [psycho-neuroses] we are dealing with patients who develop difficulties in the ordinary course of their home life, assuming a home life in the pre-latency period, and assuming satisfactory development at the earlier infantile stages. In the second category, the analysis of the depressive position, we are dealing with the mother-child relationship especially around the time that weaning becomes a meaningful term. The mother holds a situation in time. In the third category there comes primitive emotional development, that which needs the mother actually holding the infant. (1954/1958, p. 279)

Whenever we meet the two latter types of patients, their emotional age, from the perspective of the theory of maturational process, at least antedates the stage of concern. Clinically, these patients often need to regress to dependence, regain hope and then restart the maturational process. Accordingly, the therapist must perform the role of a facilitating environment, which must be studied in relation to the details of the maturational process so its functions and changes can be understood, and we can adjust our behavior and the setting to the maturational needs of the patient. If the therapist cannot provide a suitable emotional environment consistent with the patient's emotional age and maturational stage, there may be a mismatch and it may not be possible to start the actual treatment. This is because, in some cases,

> […] it turns out in the end or even at the beginning that the setting and the maintenance of the setting are as important as the way one deals with the material. In some patients with a certain type of diagnosis the provision and maintenance of the setting are more important than the interpretative work. When this is true one may feel challenged and it is quite possible that the right thing to do is to end the treatment on the grounds that one is not able to meet the demands of the patient. (1964/1989, p. 96)

2. The growable maturational process and environmental theory

It is an honor to share with you the above understanding and the content that follows. This was made possible thanks to Professor Zeljko Loparic, Dr. Elsa Dias and other teachers from the Brazilian Institute of Winnicottian Psychoanalysis, who have conveyed to Chinese students so much theoretical knowledge over the years, and still provide supervisory support. Professor Loparic continues to teach the younger generation of Chinese therapists and related professionals, introducing Winnicott's *Wheel of Life* and *Environmental theory*.

In my own case, through study and clinical experience, I have learned and become more and more aware of the maturational process that people undergo in their lives. As far as I understand it, the maturation process is a process of interaction between a person's innate maturational tendencies and the environmental provision. During this process, individuals grapple with various maturational needs waiting for realization. In early life, the individual must first exist and continue to be, to later develop towards *integration into a whole person*. This tendency towards integration is essentially different from the development of instinctual life in traditional psychoanalysis, and in Winnicott's viewpoint belongs to the development of ego-needs. At a very early stage, the infant's instinctual life is still external. Without the coverage of ego-functioning, which gathers instincts and instinctual operations into ego-experiences, instinctual life has no meaning for an infant. Winnicott believes that the beginning of an infant's life is also the beginning of ego-development; the strength of the infant's ego depends initially on the strength of the mother's supportive ego and on her ability to meet the baby's ego-needs.

Infants are extremely dependent on the provision of an environment and are inseparable from it, so much so that Winnicott says,

> As we look towards the earliest roots of emotional development we see more and more dependence. At the earliest stage the dependence on environment is so complete that it is not valuable to think of the new individual human being as the unit. In this stage the unit is the environment-individual set-up (or whatever it can better be called) of which unit the new individual is only a part. (1988, p. 131)

As part of this set-up, infants have certain essential maturational tasks to accomplish from the very beginning. These overlap each other and will run through their entire life, becoming increasingly complicated. They include:

a. Integrating into a unit self in space and time

b. The psyche indwelling in the soma and becoming a person with a psycho-somatic existence;

c. Beginning object-relating; at first, one relates with subjective objects, and gradually with objects and environments that are objectively perceived.

During the stage of environment-individual set-up, the mother must hold the baby if these important basic tasks are to be achieved. Winnicott is convinced that it makes little sense to discuss small babies by themselves. Usually babies do not exist alone, but in the *mother-infant* couple of caring. Mothers perform three functions corresponding to the development tasks outlined above – holding, handling and presenting objects as an environment.

Holding is essential in caring, and can ensure that the baby's soma, psyche and personality are integrated in a complex environment. In early life, physical care of a baby is equivalent to psychological care. Improper holding may make the baby uncomfortable, and in severe cases may even convey to the baby a very primitive painful experience. For example, experiencing so-called scattered collapse for lack of being gathered; experiencing falling forever because of not being held tightly; experiencing environmental insecurity due to being unstable and uncomfortable. Good-enough holding prevents these situations from happening.

Handling facilitates the cooperation and sense of association between the infant's psyche and soma. Breastfeeding, changing diapers, cleaning the body etc. can deliver many experiences to the baby. Body interactions not only exercise the baby's muscle movements and physical coordination, but also provide materials for imaginative elaboration during rest, developing and enriching its inner world. Inappropriate handling may prevent the baby from having a real experience of its body, thereby affecting the development of motor coordination, and preventing it from forming a personal impression of its own body or individual parts of its body, as well as body sensations, movement sensations, body functions etc.

Object-presenting refers to the mother's actual presence, to her humanized adaptation that allows the baby's spontaneous actions to be responded to and realized. It is also a necessary condition for the baby to begin to develop object relations. For example, a baby naturally stretches out its hands or kicks with its legs, and being surrounded by the mother these stretches and kicks can also hit her, the other. From the baby's perspective, the experience of stretching out elicits a response, and the reaction force of the other allows it to experience the straightening of its own arms and the feeling of standing upright after stepping onto the opposite side. The infant is not aware of these processes, but the experiences lay the foundations for it to perceive reality and develop object relationships.

In the early stages, human maturation and development truly depend on the environment. This is a truth of life revealed by Winnicott. Later, this environment will steadily expand to meet the individual's further needs in the maturational process, but this later expansion will still be based on the original holding environment of the mother's lap.

The earlier the stage of development, the greater the role of the environment. When the natural environment functions well and adapts to the baby's dependence at different maturational stages, the baby only needs to keep up the continuity of being itself, slowly developing and integrating, and gradually breaking away from environmental dependence. If everything is not going well, however, and the environment cannot adapt well enough, the baby's continuity will be disturbed from the outside or inside, and it must even react to the intrusion, interrupting its own continuity of being and causing distortions in the maturational process. This is the concept of trauma in terms of the maturational process: "Trauma is an impingement from the environment and from the individual's reaction to the impingement that occurs prior to the individual's development of the mechanisms that make the unpredictable predictable." (1967/1989, p. 198)

Growing up in an unfavorable natural environment, the individual will unfortunately become vulnerable to various emotional and psychological difficulties, much like the borderline and psychotic patients mentioned above. When they seek treatment, they are looking not only for a person, a solution, but also for an environment or setting, a new environment different from the original natural one that disheartened them and can provide the opportunity for them to develop again. When we practice psychotherapy according to the Winnicottian paradigm, we must deal with maturational disorder, and based on our assessment of the patient's current maturational stage, we will provide adaptive therapeutic settings and management.

3. Case illustration

I will present a case that shows the interweaving between changes in the setting and a patient's growth.

In brief, I have been treating this young male patient for five years and many changes in the setting occurred during this time, but the treatment was maintained as I accompanied him through puberty. Recently, as he ceased being a *patient* to become *a young man* growing up and ready to enter society, our treatment seems to come temporarily to an end.

Treatment began when the patient was about 15 years old. Due to high academic pressure and unfavorable interpersonal relationships, he developed auditory hallucinations,

became suspicious and hypersensitive, believed himself to be extremely smart, often lost his temper and so on. He was diagnosed with an acute psychotic attack and was hospitalized. Symptoms improved after drug treatment, but he was then diagnosed with depression. I was then in charge of the psychotherapy of patients in the open ward where he was hospitalized and we began therapy. At that time, I had just started studying Winnicott's theory and this patient was one of the early cases in which I followed the Winnicottian paradigm.

The patient had been diagnosed with an acute psychotic episode, and while medication played a role in controlling the symptoms, the promoting effect of the hospital environment cannot be ignored. The open ward he lived in was similar to a double room-style accommodation in a hotel, but he could live in a single room with his mother. This reminded me of Winnicott's words, "What I mean is that it is one thing if a patient simply breaks down, and it is another thing if a patient breaks down into some new environmental provision that offers reliable care." (1967a/1989, p. 197)[1]

This is an important clarification, for my patient (and, I suppose, those like him) wasn't actually aware there was a hospital and an open ward that could provide a proper environment. Fortunately for both of us, he had been hospitalized there and I was his therapist. I believe we created the environment (and a relationship since then) that he needed. Furthermore, I suppose that if he recognized our setting as a good environment, he might have become the second case in the quotation and – someday, somehow – re-experience the collapse and then truly recover.

After about a month, he was discharged from the hospital and we continued treatment in a consulting institution. This institution allowed us to arrange our schedule more flexibly and use a more personalized consulting room. I was in the early stages of learning Winnicott's theory and my own work paradigm was still changing. So, during the first two years of treatment, we met three times a week. I was still accustomed to making interpretations during sessions, but with regard to the setting I accepted that he was sometimes late and stayed overtime, allowing him to explore his own schedule and rhythm. Gradually, this enabled him

[1] In a later comment from my clinical supervisor, Dr. Elsa Dias, she insightfully distinguished the actual situation of my patient's break-down from my ambiguous understanding. She pointed out that, indeed, Winnicott was referring to the difference between one thing (a patient that simply breaks down) and another thing (a patient that recognizes an environment capable of providing reliable care, in which he/she can collapse). In her view, my patient belonged to the first case. Initially, he had simply collapsed. But he was then fortunate enough to be taken to that hospital, where I became his therapist just as I was studying Winnicott's maturational theory. Thus, he was able to have the environment he needed. It was not that he had recognized a good environment, but rather that he had collapsed because he needed it.

to experience some autonomy and control. I also strove to book the same room for our sessions so he could familiarize himself with our treatment and the treatment environment, and feel safe enough to reveal his subjective world. These were experiences that he had somewhat lacked during his growth process. His mother is an impatient, strong and very intellectual woman, but is emotionally fragile and avoids emotional involvement. It was difficult for the patient to establish a delicate emotional interaction with his mother when he was a child, nor was he allowed to explore the relationship spontaneously.

The effect of this period of treatment was that he became increasingly able to accept some of his immature and chaotic aspects. He was also able to go back to school, and although it was difficult, he tried to adapt to school arrangements and classmate relationships.

In the two following years, as I studied abroad, we had to switch to online video therapy. He was very resistant at first and did not want to meet online. And I was not sure whether he could maintain the treatment relationship if the many ins and outs of personal contact were lost during online therapy. However, we both agreed that he needed to continue treatment – so we persisted. During this period, to compensate for our different time zones, I had to schedule either earlier and later appointments, and to ensure that my internet access was functional and that my workplace was stable. Nevertheless, it was inevitable that occasionally he had to accept some compromise in the setting, which took some time for him to adapt to.

It now appeared that the reason he stuck to online therapy was our face-to-face experience in the previous two years, which let him accumulate reliable impressions of me. Another phenomenon was unique to our online therapy: he let me know during last year's online therapy that when he faced the screen, he often talked to me as if he were *talking to himself in the mirror*. He described that he saw on the screen his own image and the therapist's image in the same frame. Thus, when he spoke, he was actually speaking to himself. In this way, he seemed to combine identification with the therapist with a certain part of himself, and gradually established a personality – that of a person who understood psychology and used his personality to deal with school life and to protect his true self. It was only during sessions, when I listened to him sing, that I could grasp some of his true emotions.

I believe this phenomenon—him talking to the therapist on the screen as if he were talking to *himself in the mirror* – is very important because despite the therapy being online, he used it creatively, embodying through me *the mirror-role* of the mother in child development, as Winnicott described in his 1967 paper, "Mirror-Role of Mother and Family in Child Development". Winnicott's main thesis is that in the early stages of the mother-infant relationship, the infant, in order to emerge creatively from the mother-infant set-up, needs to

have been seen as itself first. Thus, the infant depends very much on the mother's facial responses when it looks into her face and, therefore, a mother who adapts to her infant's need will help it establish a true sense of self. Winnicott suggested that,

> What does the baby see when he or she looks at the mother's face? I am suggesting that, ordinarily, what the baby sees is himself or herself. In other words the mother is looking at the baby and what she *looks* like is related to what she *sees* there. (1967b/1971, p. 151, italics in original)

We can, and should see the analogy between this essential feature and the clinical situation. Winnicott confirms that,

> This glimpse of the baby's and child's seeing the self in the mother's face, and afterwards in a mirror, gives a way of looking at analysis and at the psychotherapeutic task. Psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving the patient back what the patient brings. (1967b/1971, p. 158)

Of course, it is difficult to be a human mirror for our patients, but my patient's case, because of how he used online therapy, not only confirms Winnicott's insights, but also inspired me to be more confident about online therapy. Besides talking to me, my patient needed above all for me to see him, and for him to see my facial feedbacks, my tone of voice, my attitudes – that is, all kinds of non-verbal communication. And what I provided, in this case, was guided by what he needed to create by mirroring me. It turned out that my patient's maturation and creativity would always surprise me – provided I was able to adapt sufficiently to him.

Luckily for us, it was not until the middle of this year that we were able to resume face-to-face sessions as the pandemic was brought under control in China. Now he is no longer the sick boy he was at the beginning. He has graduated and plans to leave his parents to study abroad. He is also considering finding a job and earning money to gather some social life experience. We have changed treatment location once again and this time he showed keen interest in the new place, rather than resistance. Regarding schedules, he also purposely began being punctual. I intuitively feel that perhaps the time is not far for us to say goodbye for a while.

4. Summary

The Winnicottian therapeutic setting shares similar roles and forms with facilitating environments throughout the individual's maturational processes. Therefore, the emphasis on establishing and maintaining the setting should basically, if not totally, lay on the therapist's

personal adaptation to the patient's needs. In the long run, as ones grows in concert with the patient's development, the therapeutic work will gradually reflect what the patient brings, functioning as a human mirror, much like the mother's face mirrors what is there for the infant to be seen. As a result, I'm always encouraged by Winnicott, as his outlook has led me to truly believe in the work I do.

> […] this way […] if I do this well enough the patient will find his or her own self, and will be able to exist and to feel real. Feeling real is more than existing; it is finding a way to exist as oneself, and to relate to objects as oneself, and to have a self into which to retreat for relaxation. (1967b/1971, p. 158)

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