BOLETIM WINNICOTT NO BRASIL, Area IWA, Section Articles, 2023/04/24

Resuming Maturation: The Winnicottian Clinical Approach to Psychoses[*]

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> All this can be very clearly demonstrated in psycho-analytic work provided one is able to follow the patient right back in emotional development as far as he needs to go, by regression to dependence, in order to get behind the period at which impingements became multiple and unmanageable. (1949/1958, pp. 192-193)

1. Introduction

At many of our scientific meetings, whatever the topic at hand, one may in principle approach it from various theoretical angles. However, this particular topic – "The resumption of maturation" – is eminently Winnicottian and cannot be developed outside that perspective. The title of this paper comprises the ideas of maturation, that the maturational line of the individual can be broken, interrupted or lost, and that it is possible, in principle and under certain circumstances, to resume it. The idea of resuming maturation involves a conception of regression not to libido fixation points, but of a return to a situation of dependence – an essentially relational rather than intrapsychic notion, therefore. In view of this and given the sense of cure, which it implies, regression in this sense is not a sign of disease – as it nearly always was interpreted in traditional psychoanalytic theory, but a first step towards health. We are in an irrevocably Winnicottian terrain.

We will not examine here the foundations of Winnicottian clinical practice regarding maturation and, in particular, psychoses, nor shall we compare it, point by point, with traditional psychoanalytic practice. I only stress that understanding psychic disorders as disturbances of an individual's maturational processes – which I will henceforth call maturational disorders – especially if one takes into account the initial state of dependence – has clinical implications that radically change the analytical setting, the role of the analyst, and the notion of cure when compared with traditional psychoanalysis. Springing from the study and treatment of neuroses,

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[*] This paper was originally a lecture given in Lisbon (2014), at the Luso-Brazilian Congress on the psychoanalysis of Donald W. Winnicott, whose general theme was "The resumption of maturation." After being expanded and corrected, it was published in Portuguese with the used here, "A clínica winnicottiana das psicoses: a retomada do amadurecimento", in *Se…, Não… Revista Portuguesa de Psicanálise e Psicoterapia Psicanalítica*, 2014, v. 5, no. 2, pp. 205-222. New additions were made to the English version.

the traditional analytical setting is based on the theory of the development of sexual functions, and presupposes an individual fully constituted as a unit and capable of relating to others. An entirely different perspective opens up when the setting and the analyst's tasks are guided by Winnicott's theory of maturational processes. Based on the study of the primitive stages and of psychoses, it aims to understand and treat emotional disorders in general, yet must also account for the emergence of schizoid phenomena in all kinds of patients and the treatment of cases that are clearly schizoid or borderline.

To better situate the perspective from which Winnicott works, one must recall that he was a researcher, not exactly of the mind, and even less of the psychic apparatus, but of human nature. Striving to properly understand the human conundrum, he rejected the Freudian heuristics that resorts to a dynamic of instinctual, superstructural and intrapsychic forces. Instead, he made detailed observations of the actual history of an individual's relations to his or her environment from very early on in life. This direction of thought is probably due to personal factors – Winnicott's own biography – but also to his work as a pediatrician systematically caring for babies and their mothers, and his concomitant work as psychoanalyst of psychotic adults, especially those who managed to regress to dependence. These people and the problems they shared in a clinical setting that favored dependence allowed Winnicott to glimpse essential aspects of human existence, which for him are not accessible when one studies a healthy or a neurotic individual.

At the beginning of his career as a pediatrician, and having begun his training as a psychoanalyst, Winnicott noticed that traditional psychoanalysis attempts to account for infancy and treat psychoses based on what it theorizes happens to 2-, 3-, 4- or 5-year-olds and the Oedipal issues they face. He, on the other hand, tended babies only a few weeks old who were already emotionally ill, who appeared scared, very agitated or manifested a kind of anorexia with no signs of physical problems. It was not possible, due to their extreme immaturity, to assign any of their difficulties to the central hypothesis of traditional psychoanalysis, namely the Oedipal triangulation predicament, which presupposes a high degree of development, including mental development. He thus concluded that there must be a field of very primitive problems that evades the Oedipal paradigm.

In the face of this, Winnicott's theoretical effort went towards rendering explicit the initial stages of a baby's life, its pursuit of contact, the "magic of intimacy" and of the communication that unfolds between itself and the mother (when she is good enough), and the specific nature of the difficulties babies face at this early stage. He connected such difficulties with those of psychotics to relate to the reality of their own selves, of life and of the external

world. It is at this pre-verbal, pre-symbolic and pre-representational stage that he found both the roots of psychological health and the many hindrances to living and feeling alive that afflict psychotics. The issue that impelled Winnicott was knowing which environmental conditions favor or fail to favor the processes by which a baby – immature and highly dependent at the beginning – becomes a viable person, capable of establishing relations with external reality, finding meaning in being alive and taking reasonable care of itself. If these conditions are not in place at this early stage, the individual may never constitute him or herself as a person and, therefore, may fail to experience something as sophisticated as a triangular (three-body) relationship with others, i.e., more specifically, the Oedipal situation.

Starting from the notion that human beings are essentially relational creatures, and fully drawing the consequences of the baby's immaturity at the beginning of life, Winnicott emphasizes the crucial significance of the environment, specially early on – against the main views of the time that stressed the intrapsychic. He says, for example, that babies who do not receive good enough care in early life "do not fulfill themselves, even as babies. Genes are not enough" (1968/1987, p. 94). Since environmental care is an imponderable element, one must concede that the process of attaining life may fail, given that biological birth does not coincide with ontological birth. There are physically healthy babies who die because they do not find at the beginning a basis upon which to be, to keep on living and to continue to be. There are others who do not necessarily die but who "by the persistence of those in care […] become seduced into feeding and living, although the basis for living is feeble or absent" (1988, p. 107 orig. 127). In such cases, the individual grows up, but although biologically alive and even healthy, does not manage to live or to feel alive and real, remaining immature in a basic and fundamental sense.

It was in the light of these findings, provided by his psychotic patients, particularly those who regressed to dependence – because these, but not babies, are able to tell us something about the nature of what afflicts them –, Winnicott formulated his theory of psychoses and antisocial tendency as environmental deficiency disorders. From there he reformulated the theory of other disorders – psychosomatic ailments, depressions, neuroses, perversions, paranoias. Whereas traditional psychoanalysis – and Lacan along with it – relates psychoses to castration issues or, as Klein does, to the death instinct, but in either case linked to some derangement of the instinctual forces, neglecting the role of the environment, for Winnicott psychotic disorders are of a different nature: they are, as he states it, environmental deficiency disorders – taking the therapeutic task in another direction. What psychotics lack, says Winnicott, is not properly the principle of reality, but more fundamentally, a sense of the reality of the self and of the world

where they live. Their difficulties and problems, he emphasizes, "are especially irksome because of their being not inherent, not so much a part of life as a part of the struggle to reach a life – successful treatment of a psychotic enables the patient to begin to live and to begin to experience the inherent difficulties of life." (1988, p. 80). Elsewhere, he writes, "some must spend all their lives not being, in a desperate effort to find a basis for being" (1966b/1984, p. 96).

This is not an issue for neurotics. If there are no doubts about the consistency of their initial experiences, they probably had a good beginning, attained the unit status and a sense of being real, and are capable of interpersonal relations. They might fall ill when having to deal with conflicts emerging from instinctual life in the midst of triangular relationships, but analysis does not reveal doubts about the reality of the self, only problems related to defenses they built up against anxieties originating in the management of genital instinctuality and the fantasies derived from it.

Of psychotics, "who are all the time hovering between living and not living" (1966a/1971, p. 139), one cannot say that their troubles come from intrapsychic conflicts, which would indicate something "deep", something repressed in the unconscious, seeing they lack the necessary maturity. According to Winnicott, "it is not possible for a split personality to have an [repressed] unconscious, because there is no place for it to be" (1964/1989, p. 488 orig).[1] Rather, their troubles stem from a "earlier" domain, and have to do with a basic inconsistency that erodes all sense of reality. Although they may present themselves as – and actually be – capable of dealing with the demands of life, due to the precocious formation of a false self that promoted an artificial integration and reveals itself as real, these are individuals whose initial experiences were so deficient or distorted that the analyst will be the first person in their lives to provide some essential things that can only be offered by what is called a "good enough environment". These patients do not properly have a history, because traumatic discontinuities have repeatedly broken their continuity of being, leaving a fragmented past that is hard to reconstruct chronologically.

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[1] Having shed light on the most primitive stages of life prior to the establishment of the unit self, Winnicott understood that to harbor primitive psychosomatic experiences, which are never properly conscious, one needs a notion of the unconscious that is not the repressed unconscious of Freud. He says: "Whereas the unconscious [original, which will simply be forgotten] generally is the storehouse of the richest areas of the person's self, the repressed unconscious is the bin in which is held (at great cost in terms of the mental economy) that which is intolerable and beyond the capacity of the individual to accommodate as part of the self and of personal experience." (1963a/1965. p. 218).

A young adult patient of mine, who totally despaired of the possibility of life making sense and of people actually communicating, once told me, “I was socialized before becoming a person. I know and I follow very well what people expect of me, but nothing has ever made any sense. I have always felt isolated, outside the human realm; I don’t feel real, I don’t feel the world or that other people are real. I have no history. I don’t know why I live or why I keep on living.” This man had no problems with the principle of reality, but lacked the sense of reality.

From this perspective, it is natural for there to be crucial differences in the analytic setting and in the therapeutic task, depending on whether the patient is neurotic or psychotic. Regarding method, for example, interpretation, which neurotic patients need to elucidate unconsciously repressed contents, may be too invasive for psychotics, overwhelming their maturational capacity and thus repeating the pattern of environmental failure, insofar as the environment has failed at personal communication and has shown itself incapable of identifying with the patient. An interpretation in the traditional sense can also be a traumatic intrusion for stressing the external and separate existence of the analyst too early on, and for referring to an I that is still not there. In cases of psychosis, the emphasis of treatment should fall on managing the clinical situation, especially if the patient is in a state of regression to dependence and can only relate to the analyst as a subjective object.

2. Regression to dependence

Having in mind the nature of psychosis and the needs of afflicted patients, Winnicott states quite strongly that if one wants to get to the heart of psychotic pathologies, regression to dependence is necessary.

But how does one know when a patient needs to regress to dependence? When the patient begins to show acute sensitivity to the quality of the analyst’s presence/absence, notices every detail of the environment and is startled by any little change in it; when, furthermore, he or she also begins to make use of a special provision conceded by the analyst to become – even if only momentarily – dependent, disintegrated or out of reach, delirious or mad, or to slide into an amorphous state in a way that was never possible in early life and the state he or she was entitled to was that of non-integration. And this is only possible in conditions of maximum dependence (see 1963a/1965, p. 217).

What is needed for dependence to occur, if it reveals itself necessary? The answer is that there is nothing specific to do except offer an analytic setting that is above all reliable, as well as regular, customary, capable of preventing unforeseen things from happening, and prepared

to welcome and care for the patient during the regressive stage without shocks or surprises.[2] If the patient needs to return to the point in which his personal maturation halted, and the analytic setting provides the requisite special conditions (trustworthiness and personal consistency of the analyst), he or she will regress to dependence. I should also point out that when caring for a patient in regression, the analyst must be willing to stop using, for an indeterminate amount of time, the sophisticated and intricate psychoanalytic knowledge that always was his or her working tools. The analyst must focus not on the extremely interesting symbolic nexus found in the interpretation of the unconscious during transference, but on the simpler, more specific details that the patient brings in need of understanding and response. Regarding psychotics, the most reliable work tool is the person of the analyst, his or her real interest in, and ability to identify with, the person of the patient.

What, then, is the actual purpose of regression to dependence? The more general one is to start over a beginning that was so unsatisfactory that the individual was unable to feel that life is worth living. In particular, these patients need to return to a moment prior to their trauma, so as to recoup the lost thread of hope and spontaneity. They also need to experience, perhaps for the first time in their lives and for as long as necessary, a holding, regular and predictable environment, so that by gradually coming to rely on it, they may, over time, start "to believe in…", "count on…", and eventually resume their path to maturation.

All this is far from easy. Most often, these persons never experienced reliability, or if they did, it was deficient they have no experiential record of holding. Rather, they harbor a permanent fear of losing contact, of disintegration, of "falling forever"; or, still, they might have experienced samples of affectionate acceptance, but these where so irregular and unpredictable that it was not possible to establish trust, the sense of "being able to count on." And because they never safely lived and incorporated the experience of trusting, they can never allow themselves any hope, because for them hope is ever so close to disappointment. These persons, more often than not, have spent their lives self-sustaining themselves, or living within their minds, or balancing somehow on a false integration that is always about to fall apart. They might even know, intellectually, what it means "to count on," but this is of little use to them.

Sometimes it takes a long time to establish the experience of reliability, and this is why, according to Winnicott, there are cases in which the only thing one can do is to wait: "As a psycho-analyst I have had very good training in this matter of waiting and waiting and waiting" (1958b/1965, p. 80). Naturally, waiting has certain specific qualities, one of them being that the

[2] On the issue of reliability in the analytic setting, see Dias (2011).

analyst must not despair or even become impatient. Because of their intense fear of beginning to trust, patients do all they can to discourage us and thus confirm their despair, taking refuge once again in a new defensive organization, on which by now they have become experts*,* and giving up the fight. One must slowly overcome the patients' mistrust and the self-sustenance and self-sufficiency it entails, without appealing to their intellectual understanding. Another quality of the analyst's waiting is to not try to "cure" patients, or console them, or encourage or minimizing what they are going through. Patients *will know immediately that we fear their state and we will not hold them as they currently are.*

In the clinical case with which Winnicott illustrates Chapter 4 of *Playing and Reality*, a highly despondent patient speaks of her deep feeling of not mattering to anyone. I quote their dialogue to show how Winnicott does not comfort her, nor does he minimize the situation; he just preserves and reproduces, for her to listen, what the patient herself brings:

> "It's a desperate feeling of not mattering. I don't matter…there's no God and I don't matter. Imagine, a girl sent me a postcard from holiday."
> Here I said:
> "As if you mattered to her."
> She:
> "Maybe."
> I said:
> "But you don't matter to her or to anybody."
> She:
> "I think, you see, I've got to find if there is such a person [for whom I matter], someone to matter to me, someone who will be able to receive, to make contact with what my eyes have seen and my ears have heard. Might be better to give up, I don't see… I don't…" (1967b/1971, p. 59)[3]

More than anything else, the analyst's task is to show understanding of what the patient brings and, silently, provide reliability. A patient of mine, who sat opposite me – a highly paranoid middle-aged woman – asked if she could place against her back a thin, firm cushion she had found in the waiting room to sooth a recent lower back pain. In the following session, I noticed she was slightly disappointed for not finding the cushion where she had left it. After that, finding the pillow in that place was a sign that I was waiting for her, that I had thought of

[3] It should be noted that, given the patient's recollection that she had received a postcard from a girl on vacation, Winnicott *did not* say, "Well, it seems like at least one cares for you," consoling the patient and attempting to relieve the despair of not mattering to anyone. What he said was: "As if you mattered to her." She answered: "Maybe." To which he nodded, assuring her that, despite this fact, he continued to understand the basic feeling: "But you don't matter to her or to anybody."

her and had prepared her place. We never needed to talk about this, but I took the care of placing the cushion whenever she had an appointment. Only when she got better was she able to say how important it had been to be able to count on that caring gesture and attitude.

3. Primitive trauma: unthinkable agonies

There is still another aspect of the need for psychotic patients to regress to dependence: in the specialized conditions of the therapeutic environment, by experiencing the analyst's reliability, the patient sees him or herself compelled to reach the "original madness" dwelling within and that was never properly experienced. Let me explain: this "original madness" was that instant when, as a baby, one suffered a traumatic interruption one's line of existence, that is, lost momentarily the line of continuity of being due to a failure in the environment. Technically, the baby suffered an unthinkable agony: "Death for an infant at the beginning means something quite definite, namely *loss of being on account of prolonged reaction to environmental impingement*" (1988, p. 134 – italics added).

Babies who suffer traumatic interruptions in their line of being take a concrete toll that is very hard to repair. Unaware, they carry with them unthinkable agonies, i.e., a latent memory, irretrievable through representation, of a disaster that happened with their I (at a moment when there was yet no I). Their entire lives from then on is unconsciously oriented towards avoiding the repetition of that breakdown.[4] In general, they feel odd and have fears they cannot understand.

Winnicott provides the following example of a primitive trauma, i.e., of an unthinkable agony. He points out that a small baby's personal psychic reality is still quite fragile, meaning that, on its own and for a long duration, it remains incapable of keeping alive the feeling of the mother's presence and of itself dwelling in a body. Winnicott says that if the mother is away

[4] The concept of the unconscious implied here is not the repressed unconscious of traditional psychoanalysis, which requires a degree of maturation that cannot be presumed at this initial moment, namely, a unit self, separated from the not-me, the structuring of an inner world that harbors censurable material and an instance of moral censure which, through dreamwork, disfigures the censurable material. Regarding the initial experiences, whether they are supportive of the self or traumatic, which interrupt the continuity of being, one may speak, with Winnicott, simply of unconscious, or of primary or original unconscious, like that which keeps the psychosomatic experiences that antecede mental functioning and, therefore, are not amenable to representation. These primitive experiences, prior to the constitution of the self and of the internal world, never reach consciousness, or tend to be forgotten rather than repressed. To refer to the negative aspect of the primary unconscious related to traumas, Z. Loparic coined the expression "un-happened unconscious," which is when something should have happened (for instance, a response to the baby's spontaneous gesture) but did not; the gesture fell repeatedly into the void and prevented an integrative experience.

for x time, the baby becomes restless; if she is away $x + y$, it becomes distressed; but if she is away for $x + y + z$, the feeling that she exists dies away for the baby, who is left with nothing and falls into a kind of void or unreality.

One of the experiences I had with a long regression to dependence was with a 40-year-old man whose childhood home was truly chaotic. For a few years, at the beginning of his analysis, the weekend breaks were unbearable for him. At some point of this early stage, he told me during those intervals he often underwent terrible moments, losing contact with me and with himself, while the reality of what we lived during sessions became distant, as if it had never existed. Although he was quite aware, intellectually, that our encounters did indeed take place, at times he felt as if they were something illusory, purely imagined. My last session on Friday was with him. "On Saturdays", he said, "things still exist, although they seem somewhat fuzzy, but on Sunday afternoons, I lose everything: it is as if I were thrown into a vacuum where nothing exists, time stops and I remain captive there; there are no memories onto which I can hold, no reality that makes any sense, and I will stay there forever". It was this patient who taught me that it was not exactly me, as a unique person, that he missed on weekends. As a baby, he needed me as a living, welcoming presence near him, needed to be seen by me to be able to get in touch with himself and feel real. Without my intermediation, he was lost to himself.

Winnicott distinguishes seven kinds of unthinkable agonies, as if to retain some specificities, but they are all interwoven and emerge as a group.[5] It is hard to put into words what these agonies are, but one can certainly state that they are not anxieties due to the loss of an object or to no longer loving an object, since in the earliest stage there is yet no object to be lost nor feelings in place. Actually, there is not even a constituted "subject" who can suffer losses. These are, therefore, *thinkable* agonies, much like castration anxiety. The so-called *unthinkable* agonies occur when there is still no unit self capable of making them a personal experience. Something happens – or, more accurately, does not happen when it should – that forces the baby to react, breaking its continuity of being. The baby, however, who has not yet integrated into an established unit self, suffers a trauma, but is not capable of experiencing it. It

[5] There is mention of five kinds of unthinkable agonies in "Fear of Breakdown" (1963b/1989, p. 72); some of them are mentioned again in other texts. These are: *fear of returning to an unintegrated state* (or *fear of dependence*), *of falling forever*, *of losing psycho-somatic collusion*, *of losing the sense of real*, and *of losing the capacity to relate to objects*. I found another two slightly different kinds: the first is fear of "complete isolation because of there being no means for communication" (1968/1987, p. 99) and the second is a fear of a total "absence of orientation" (1967a/1989, p. 198).

is thus thrown into a state of confusion and/or unreality, which, however severe, might be imperceptible to an observer.[6]

Immediately following the trauma, a defensive split emerges: the true self, which is the seat of spontaneity, retreats and becomes isolated and inaccessible, while another portion of the personality falsely organizes itself, because it is defensively integrated from the outside in, based on environmental patterns, and takes on the task of dealing with external world, adapting itself to its demands and, thus, protecting the true self from being struck again. Around this splitting, more specific defenses are organized to attain a kind of invulnerability that seeks to prevent – forever and at any cost – the return of the unthinkable agony. This defense system is, essentially, what psychosis is for Winnicott.

The individual, despite everything, continues to grow physically and intellectually, but lives only from an outer shell, i.e., the introjected environment, not from his or her core, one's personal impulse, which is creative. And "may achieve a deceptive false integrity, that is to say a false ego-strength, gathered from an environmental pattern" (1955/1958, p. 297). By becoming purely reactive and, therefore, lacking a creative impulse, that individual neither attains life nor feels alive. Since nothing is experienced in the first-person, a permanent feeling of the uselessness of life sets in. Living becomes an ongoing task of avoiding the unpredictable. These individuals wander about in the world, often giving the impression of absolute normality, but they do not exist as persons; it is as if they had not been born. Franz Kafka, who apparently knew this well, wrote in his diary: "Not yet having been born and already having to walk the streets and talk to people" (Kafka, 1985, p. 554).

It is to this state of affairs that Winnicott warns analysts of the possibility of making mistakes. Many times, that which presents itself in the clinic and appears to be a neurosis, family drama and all, is nothing but an internalization of the primitive environment. In these cases, he claims, we are more successful by recognizing

> […] the patient's non-existence than by a long-continued working with the patient on the basis of ego-defence mechanisms. […] This unrewarding work is only cut short profitably when the analyst can point to and specify an absence of some essential feature: "you have no mouth," "You have not started to exist yet," "Physically you are a man, but you do not know from experience anything about masculinity," and so on. These recognitions of important facts, made clear at the right moments, pave the way for communication with the True Self. (1960b/1965, p. 152)

[6] The fact that this kind of primitive trauma is imperceptible for an observer renders debatable the close bond that often is woven between Winnicott's theory and Esther Bick's technique for observing babies.

4. Fear of breakdown

What reaches us in our clinical practice are these highly organized and rigidly maintained defensive systems. Behind all the defenses there is a permanent threat of confusion and disintegration. In some cases, years go by before there is even a slight loosening of the defensive organization. In others, breaches appear in the system, usually as highly complex phenomena that Winnicott called "fear of breakdown": the patient reports feeling constantly threatened by dangers lurking just around the corner; there is always an imminent disaster awaiting: death, madness, blindness, emptiness, disorganization, terminal poverty. The term "breakdown" was chosen for being sufficiently vague to comprise various kinds of fears, but the expression *fear of breakdown* indicates that the individual lives under the threat of potential disintegration of the falsely erected defensive organization.[7]

The difficult and complex issue here is that while the individual's entire life is unconsciously organized to avoid repeating what happened, it must be emphasized that the disaster did not actually occur, or as Winnicott puts it: "this thing of the past has not happened yet because the patient was not there for it to happen to" (1963b/1989, p. 92). "Was not there" means that the individual did not yet exist as an "I" who might indeed experience the trauma in the first-person as something that actually happened to him or her.

Because this belongs to the realm of the unthinkable – occurring prior to the beginning of a functioning intellect and, moreover, not amenable to representation – the original trauma cannot be recalled. It cannot, therefore, be sought as if it had been lost or disfigured in the furrows of the repressed unconscious. Analysts cannot hope to find it by working to weaken the repressive forces, for it is not censured material.

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[7] Who gives us a simple and acute description of the fear of breakdown is Ingmar Bergman. At age 88, one year before his death, he gave a long and final interview to Swedish documentary filmmaker Marie Nyreröd on his island of Faro, which resulted in the documentary *The Island of Bergman* (2006). While showing his curious and unusual habitat, Bergman spoke of his personal history and his work as filmmaker, clearly autobiographical. The documentary begins with Bergman walking in the garden of his property, saying: "Demons do not like fresh air. They want you to stay in bed, afraid." At the end of the movie, he returns to his demons and tells Marie to make a list of "some of them". The worst of all, he says, is the demon of catastrophe, disaster: "The truth is that I have a high degree of preparedness for disaster. This means you imagine that everything you do in a day, everything that you plan to do the next few days will go extremely wrong". This "state of preparedness" indicates a high degree of alertness and the feeling of imminent disaster, which will get you just around the corner. After this, says Bergman, comes the demons of fear, of anger and of rancor. He says he is grateful to life for not being plagued by the demon of nothingness, which is "when my creativity or fantasy abandon me. Things become entirely silent and empty. And there's nothing there. But", he adds, "this never happened to me".

The patient, however, needs and is even compelled to move closer to the "madness" that dwells in him or her. And not being able to remember it, will have to relive it, because, as Winnicott says, unthinkable agonies *cannot become part of the past unless they are experienced for the first time in the present*. This means that the patient needs to bring the trauma up to date into the present and relive it. If the patient experiences a highly reliable environment in the setting, he or she will then use a failure of the analyst (almost always one that resembles the original failure) to return, through regression to dependence, to a moment prior to the trauma. This is not as difficult as it seems because, as imperfect humans that we are, analysts will always fail. The analyst's failure, reproducing the original environmental failure, will be experienced for the first time and, finally, perceived, with the analyst's help, as a failure *of the environment*. It should be noted that the analyst's failure is sometimes delusionally enhanced by the patient, but it is a failure unearthed by the patient's extreme susceptibility stemming from the regression to dependence. (A gross and entirely objective failure cannot serve this purpose.) At this point, I believe it is worth quoting a longer excerpt from Winnicott's text, "Clinical Varieties of Transference" (1955/1958):

> Others may be surprised, as I was, to find that while a gross mistake may do but little harm, a very small error of judgment may produce a big effect. The clue is that the analyst's failure is being used and must be treated as a past failure, one that the patient can perceive and encompass, and be angry about now. 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 countertransference.
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> In these phases of analytic work that which would be called resistance in work with neurotic patients always indicates that the analyst has made a mistake, or in some detail has behaved badly; in fact, the resistance remains until the analyst has found out the mistake and has tried to account for it, and has used it. If he defends himself, the patient misses the opportunity for being angry about a past failure just where anger was becoming possible for the first time. (1955/1958, p. 298)

If the analyst survives this confrontation and does not put up his or her own defenses, but welcomes and acknowledges the feelings conveyed by the patient's complaint and accusation, the patient may for the first time feel anger and rage, and thus blame – through the analyst – the original environment that prevented his or her maturation process from evolving. Naturally, this can only happen in the special conditions of an analytic setting with a high degree of reliability, so that the patient can allow him or herself the madness that is only granted to babies.

All this, Winnicott says, "… has the germ of healing in it. It is a process of self-cure that needs your [the analyst's] help; and in some cases it works" (1963a/1965, p. 228). The analyst is naturally

> […] bewildered by finding that the patient is able to be more and more mad for a few minutes or for an hour in the treatment setting, and sometimes the madness spreads out over the edges of the session. It requires a considerable experience and courage to know where one is in the circumstances and to see the value to the patient when the patient reaches nearer and nearer to the X which belongs to that individual patient. Nevertheless if the analyst is not able to look at it in this way, but out of fear or out of ignorance or out of the inconvenience of having so ill a patient on his hands he tends to waste these things that happen in the treatment, he cannot cure the patient. Constantly he finds himself correcting the delusional transference or in some way or other bringing the patient round to sanity instead of allowing the madness to become a manageable experience from which the patient can make spontaneous recovery. (1965c/1989, p. 128)

This passage appears shortly after a warning that in a case such as this, if the situation is addressed with the psychiatric intent to cure, "…the whole point of the breakdown is lost because in breaking down the patient had a positive aim and the breakdown is not so much an illness as a first step towards health" (1965c/1989, p. 126).

Be that as it may, one should bear in mind that if a patient is able to approach an unthinkable agony it is because there already is some organization of the ego in place, or, more precisely, a self whose level of integration renders it capable of addressing and elaborating these primitive traumas.

5. The analyst and the regression to dependence

Winnicott says that in our therapeutic work with psychotic patients we often have doubts whether what motivates us in our clinical work is good or evil, because many times we need to make ill people who are successful and who function well in their lives and with their families. We need to make them ill at least for a while. As part of the treatment, patients will have to break down, i.e., to breach the artificial defensive organization on which their life had been balancing. In such cases, the analyst needs to be able to play the role a mother nursing the infant within the patient.

Winnicott illustrates this point with the case of a 40-year-old woman, his patient, who had become a successful business executive. She despised men and dedicated her life to proving that she lacked nothing. "Eventually, all the past having been blotted out, this very ill person with a successful false self came for treatment. She came to be enabled to break down, to find

her own schizophrenia, which she succeeded in doing." (1960a/1965, p. 97). Winnicott contacted her physician and said, "if the treatment went well she would break down and need care" (1960a/1965, p. 97).

As with a sufficiently good maternal provision, also in therapeutic care, especially during a regression to dependence, the keyword is reliability. The degree of reliability needed in therapeutic work, Winnicott says, is so high it cannot be maintained outside the strict domain of professional analytic practice. By being reliable, we both protect our patients from what is unpredictable in the environment and remain consistently ourselves throughout the numerous variations that the relation will undergo due to life itself and to the movements and personal growth of the patient. By being reliable, we are also mindful that every therapeutic action is guided by the patient's needs, not by the needs of the analyst or of his or her theory.

All this relates to the survival value of the analyst. In Winnicott's clinical vocabulary, reliability and survival are interchangeable words. An essential aspect of survival is not to betray the silent agreement of dependence. It is inadmissible to allow or even clear the way for patients to display their immaturity and then, suddenly, call out their dependence and interpret it as something childlike that needs to be overcome. In other words, if when the baby within the patient displays its pain and fear, more often than not without any logic, and we then address the adult facing us, pointing out facts about reality, we will be committing betrayal – the very opposite of reliability.

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