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The case of the woman who dream of a tortoise

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Summary: This lecture presents a structural analysis of the tortoise dream case, taking as guidelines the 18 items that characterize the full structure of a Winnicottian clinical case. The case in question illustrates the treatment of a borderline schizophrenic young woman by meeting her need for regression within Winnicott's modified analysis.

The structure of Winnicott's clinical cases

A comparative study of Winnicott's clinical cases reveals that although these accounts may vary in terms of their explicit conceptual articulation or wealth of data, they illustrate at least some, if not all, of the following items:

1) The case's place in Winnicott's writings;
2) The facts of the case: clinically relevant real-life facts in the whole life story;
3) The familial and social environment;
4) The main figures of the environment;
5) The patient's personality;
6) Symptoms;
7) Diagnosis;
8) Etiology;
9) Prognosis;
10) Therapeutic setting or settings;
11) Therapist or therapists;
12) Therapeutic relationship;
13) Treatment procedures;
14) Treatment process: its dynamics and phases;
15) Therapeutic results;
16) Case summary;
17) Theoretical results;

18) Follow-up.[1]

If considered within the framework of contemporary epistemology (Kuhn, 1962, pp. 35-42), this case can be seen as a particularly rich and instructive *exemplar* of the revolutionary aspects of Winnicott's theory and clinical practice in the field of early maturational disorders like borderline schizophrenia.

I will use the 18 points above as a blueprint to elaborate a structural analysis of the tortoise dream case as presented in chapter 23 of *The Maturational Processes and the Facilitating Environment* (1965a). The analysis will take the form of a continued textual commentary of the relevant parts of the chapter. The result will be a kind of anthology of Winnicott's texts on dependence, intended to be used by students of the case and to serve as a model for writing papers with similar commentaries on Winnicott's clinical cases.

1. The place of the tortoise dream case in Winnicott's writings[2]

1) The theoretical context of the case report

> 1962a/1965, p. 249
> There is othing new in the idea of dependence, either in the early life of the individual or in the transference which develops force as a psycho-analytic treatment gets under way. What I feel may need restating from time to time is the relationship between these two examples of dependence.

> 1962a/1965, pp. 250-251
> My general objective [in the paper] is to relate dependence in the psycho-analytic transference to dependence at various stages of infant- and child-development and care.

Comment: Winnicott presented his theory of dependence in early life and during transference in various previous writings. See, for instance (1962a/1965), chapter 3 and 4, and (1989), chapter 14.

2) The main theme of the report

> 1962a/1965, p. 249
> **(1)** I need not quote from Freud. **(2)** Dependence of the patient on the analyst has always been known and fully acknowledged, and for instance shows in the reluctance of an analyst to take on a new patient within a month or two of a long summer holiday. **(3)** The analyst rightly fears that the patient's reaction to the break will involve deep changes that are not yet available for analysis. **(4)** I will start with a development of this theme.

Comment: (1) Points out that the topic Winnicott wants to develop is not specific to psychoanalysis. **(2)** A very broad time span seems to have been opened, which may include the whole of medical practice, since Hippocrates, whose oath, Winnicott remembers us,

[1] For details, see Loparic, 2023b.

[2] For other cases relevant to the present context, see Little, (1990); (1963a/1965, pp. 214-225) and (1963c/1965, pp. 235-238); (1958), cases 4 e 21; (1988), part IV, chap. 11; (1964/1987, pp. 43-46).

contemplates the patient's dependence on the doctor, down to present-day analytic treatment of psychotic borderline patients. These are individuals who have lived their lives defending themselves against a personal breakdown that occurred in early life by resorting to psychotic defense organizations, which may start early and become increasingly complex. **(3)** Gives a brief formulation of a fundamental point of chapter 23 (1962a/1965), which can be expanded as follows: the breakdown of the relationship of dependence in treatment may lead to the breakdown of the patient's existing psychotic defense organizations, and thus expose him or her to the original personal breakdown in early life. In other words, the patient becomes threatened by the annihilation of the early ego organization, of the "going on being" and of the unit self established as the unified center of spontaneous gestures that were suffered but not experienced (see 1963d/1989, p. 91). This kind of repeated trauma will require new defensive reactions from the patient, which may lead to profound changes in his or her clinical state. These changes are not accessible to ordinary Freudian analysis, since they require the provision of opportunities for regression and treatment combining management followed by interpretation, as provided only by Winnicott's theory of the maturational processes and of maturational pathology. Thus, the opening lines of this chapter distance Winnicott from ordinary analysis and announce a new theory of borderline disorders and the corresponding treatment procedures. For details on Winnicott's modified analysis, see below and Loparic, (2023c). **(4)** The development announced here is an exemplification (the tortoise dream case itself) of the therapist's failure to meet the patient's need for dependence in transference, accompanied by theoretical comments.

Further reading:

1963c/1965, p. 241
In treatment of *schizoid* persons the analyst needs to know all about the interpretations that might be made on the material presented, but he must be able to refrain from being side-tracked into doing this work that is inappropriate because the main need is for an unclever ego-support, or a holding. This 'holding', like the task of the mother in infant-care, acknowledges tacitly the tendency of the patient to disintegrate, to cease to exist, to fall for ever.

Comment: In 1971, a few days before dying, Winnicott called for a "kind of revolution" in psychoanalytic practice (see 1971/2017, p. 355).

2. Clinically relevant real-life facts of the case

1) Traumatic episodes related to the mother gathered during analysis

1962a/1965, 249
My going away [see below] re-enacted a traumatic episode or series of episodes of her own babyhood.

Comment: There is no material on these early episodes. The negative effects of Winnicott's failure (going away *too soon*) seems to indicate that the traumatic aspect was mainly temporal and related to the mother's (or parent's) absences.

2) Prior therapy

> 1962a/1965, p. 252
> The patient had had several years of analysis along ordinary lines by an analyst who disallowed regression if this threatened to become acted out and to involve dependence on the analyst.

Comment: The previous analyst worked within the traditional paradigm and, accordingly, thought that the patient's regression meant resistance and a search for secondary satisfactions, and therefore must be avoided and prohibited. This might have had a negative effect on the recovery ("bad analysis", see below).

Further reading: Winnicott's discovery of the need for regression is described in a text from 1954.

> 1954/1958, pp. 279-280
> **(1)** Briefly, I have had a patient (a woman now in middle age) who had had an ordinary good analysis before coming to me but who obviously still needed help. **(2)** This case had originally presented itself as one in the first category of my classification [patients who operate as whole persons and whose difficulties are in the realm of interpersonal relationships, that is to say, who are psychoneurotic], but although the diagnosis of psychosis would never have been made by a psychiatrist, an analytical diagnosis needed to be made that took into account a very early development of a false self. For treatment to be effectual, there had to be a regression in search of the true self. **(3)** Fortunately in this case I was able to manage the whole regression myself, that is to say, without the help of an institution. **(4)** I decided at the start that the regression must be allowed its head, and no attempt, except once near the beginning, was made to interfere with the regressive process which followed its own course. **(5)** (The one occasion was an interpretation I made, arising out of the material, of oral erotism and sadism in the transference. This was correct but about six years too early because I did not yet fully believe in the regression. For my own sake I had to test the effect of one ordinary interpretation. When the right time came for this interpretation it had become unnecessary.) **(6)** It was a matter of about three or four years before the depth of the regression was reached, following which there started up a progress in emotional development. There has been no new regression. There has been an absence of chaos, though chaos has always threatened.

Comment: (1) The patient felt that good, ordinary analysis was insufficient and that she needed help from Winnicott, who was already out of the ordinary. **(2)** Winnicott explains the need to change the diagnosis from psychoneurosis to psychosis, formulated in his own terms (false self). **(3)** Treatment took place in a private consultation room, not in hospital as the traditional psychiatric view of psychosis would suggest. **(4)** The regression was allowed to go full swing. **(5)** Describes a test of the usefulness of interpreting clinical material related to erotism and sadism emerging in the transference, which led Winnicott to doubt the results: correct, but untimely and ineffective, and later on, unnecessary. **(6)** Winnicott describes, in the terms of his theory of the maturational processes, the recovery that followed a long-term regression.

3. Family environment

No data provided.

4. The main figures of the environment

The mother. No other data provided.

5. The patient's personality

1) Physical data: female, young.

2) Mental data: intellingent.

1962a/1965, p. 253, footnote
I was clearly affected by the intellectual level of her method of presenting material.

6. The patient's symptoms

3) Life under the threat of annihilation (breakdown)

1962a/1965, pp. 252-253
Something central in her personality only too easily feels the threat of annihilation […].

Further readings on annihilation:

1. Annihilation and its cause: the failure of basic provision (see also below).

1962a/1965, p. 256
(1) In other papers I have explored in great detail the kinds of failure that constitute failure of basic provision. **(2)** The main point is that these failures are unpredictable; they cannot be accounted for by the infant in terms of projection, because the infant has not yet reached the stage of ego-structuring that makes this possible, and they result in the *annihilation* of the individual whose going-on-being is interrupted.

Comment: (1) See, for instance, (1960b/1965), sections B and C. **(2)** Another name for annihilation is *breakdown* in the continuity of going-on-being and in the establishment of the unit self. Annihilation is due to an unpredictable environment; in the worst cases, it occurs at a stage soon after birth, by a tantalizing mother, resulting in a psychotic kind of intolerable anxiety. It may come to be feared throughout life, requiring defenses to be set up (see 1963d/1989, chapter 18) and is different from castration anxiety.

2. Annihilation is not related to castration or separation.

1960b/1965, p. 41
Anxiety at this early stage is not castration anxiety or separation anxiety; it relates to quite other things, and is, in fact, anxiety about annihilation […].

Comment: Annihilation is not the frustration of the instinctual need for satisfaction, but failing to meet the basic ego-need and to establish an initial unit self.

3. Crisis of omnipotence

> 1962a/1965, p. 231
> Due to mother's failure of basic provision, there is lack of the experience of omnipotent control over the external factor.

Comment: The individual whose continuity of being was interrupted in early life and who has not established itself as a unit self is not capable of suffering because of his or her instincts. Suffering comes from *not experiencing oneself as omnipotent*, as an integrated and sovereign center of spontaneous gestures, from not being able to embrace *everything* from the external world (including one's instincts) that is presented to one's subjective world. "The ego is too immature to gather all the phenomena into the area of personal omnipotence" (1963d/1989, p. 91). The individual suffers from a lack of magical control over what is encountered – which, objectively speaking, is an illusion of omnipotence.

4) Patient's symptoms related to the threat of annihilation

> 1962a/1965, p. 252
> […] clinically of course she becomes tough and extremely independent, well defended, and along with this goes a sense of futility and of being unreal.

Comment: One of the defenses against anxiety stemming from the threat of annihilation that patients use is the false self, often abetted by their intelligence (1962a/1965, p. 253, note). In this particular case, it is a weak defense, which quickly broke down in treatment and was quickly replaced by three alternative defenses, all of them psychotic: suicidal tendency signaling total despair, dissociation, and a less pronounced psychosomatic illness, the latter calling for "mental nursing" but not producing insights or mental care that might make a difference (1962a/1965, p. 253).

5) Symptoms of ego weakness

> 1962a/1965, p. 252
> **(1)** In fact her ego is not able to accommodate any strong emotion. **(2)** Hate, excitement, fear – each equally separates off, like a foreign body, and **(3)** all too easily becomes localized in a bodily organ which goes into spasm and tends to destroy itself by a perversion of its physiological functioning.

Comment: (1) is specified in **(2)**. **(3)** States the psycho-somatic consequences of ego weakness: depersonalization. Here, spasms and other kinds of psycho-somatic disorder are not a hysteric reaction, but kinds of psychic defense reactions like those produced by convulsions in M. Little (see Little, 1990, p. 43).

6) An example of ego weakness taken from the clinical material provided during the treatment

> 1962a/1965, p. 253
> **(1)** In the course of a talk in which we made plans for the future and discussed the nature of her illness and the risks that are inherent in going on with the treatment, I said: "So here is yourself ill, and we can see that the physical illness hides an extreme reaction to my going away, although you are not able to reach to a direct feeling-awareness of this. So that you could say that I have

> caused your illness, just as others have caused you to be ill when you were a baby, and you could be angry." **(2)** She said: "But I'm not." […] **(3)** So I said: "The path is there, wide open for your hatred and anger, but anger refuses to walk down the path."

Comment: (1) Winnicott tries to help the patient give a *personal meaning* to her psycho-somatic reaction by including a time dimension: his past failure, her present illness, her future risk in treatment, but in vain. **(2)** It becomes clear that the patient cannot accommodate her emotional experiences, such as anger, into the time dimension of being, nor can she produce a life's story. **(3)** Mentally, the path for being aggressive here is open, but is not occupied emotionally, because the patient has lost her indwelling in the body, became physically ill and had no base in the body for being aggressive.

7) Hypersensitivity, revealing physical and personal weakness

> 1962a/1965, p. 252
> She is hypersensitive to all drugs and to all illnesses and to slight criticisms, and I must expect her to be sensitive to any mistake I make in my estimation of the strength of her ego.

Comment: Ego weakness appears in the clinical material as a hypersensitive reaction to some challenging aspects of external reality, and is revealed in a situation where it not commented upon and gauged immediately by the therapist, but understood and stored to be used at the right moment.[3]

8) Defensive suicidal tendency

> 1962a/1965, p. 252
> This [the tortoise in the dream] was herself and indicated a suicide tendency, and it was to cure this tendency that she had come for treatment.

Comment: Here, the anticipation of personal non-existence is part of a defense against unthinkable anxiety created in early life. The idea of suicide may not be related to an urge or a tendency, nor be part of a "suicidal ideation", but be simply an occasional defense reaction to being let down (see Little, 1990, p. 58).

9) Dissociation or splitting the personality in healthy and unhealthy parts, in urges to live and to die, reveals her schizoid state.

> 1962a/1965, p. 250
> In her healthy self and body, with all her strong urge to live, she has carried all her life the memory of having at some time had a total urge to die […].

Comment: Winnicott stresses the personal and bodily health of the patient, which allows us to see more clearly the distortions of her personality and her psychosomatic illness (see below).

[3] See Loparic, 2023a.

Further reading:

1970a/1989, p. 261
This is an achievement which becomes gradually established, and it is not unhealthy, but indeed a sign of health, that the child can use relationships in which there is maximal trust, and in such a relationship at times disintegrate, depersonalise and even for a moment abandon the almost fundamental urge to exist and to feel existent. The two things go together, therefore, in healthy development: the sense of security in a relationship maintaining opportunity for restful undoing of integrative processes, while at the same time facilitating the general inherited tendency that the child has towards integration and […] in the matter of in-dwelling or the inhabitation of the body and the body functioning.

Comment: This is not a restatement of Freud's and Klein's theory of life and death instincts, which by the way Winnicott considered to be a blunder (1987, p. 42), but an allusion to the fact that the patient was struggling, under the burden of the original breakdown being repeated in treatment, to achieve and preserve for herself a fundamental element of health – the undoing of the results of the integrative processes. This topic is, of course, related to the suicide tendency and to one of the roots of aggression, "that which belongs to the interruption of the continuity of being by impingement that enforces reaction" (1988, p. 133).

10) Psycho-somatic disorder as a new symptom

1962a/1965, p. 250
[…] and now the physical illness came as a localization in a bodily organ of this total urge to die.

1962a/1965, p. 253
[Winnicott talking to the patient] we can see that the physical illness hides an extreme reaction to my going away, although you are not able to reach to a direct feeling-awareness of this. So that you could say that I have caused your illness, just as others have caused you to be ill when you were a baby […].

Comment: Winnicott's going away (see below) repeated the original maternal trauma which had to do with letting down the patient when still a baby. As a result, new aspects appeared of the patient's defensive reaction to the threat of experiencing psychotic anxiety – a depersonalization, loss of psycho-somatic collusion, failure of the self indwelling in the body, which characterizes a true psychosomatic disorder. Depersonalization is another symptom of a weak ego, largely due to not good enough mothering, leading to a feeble indwelling in the body (on depersonalization, see 1963d/1989, p. 89).

11) Readiness for regression and the need of holding before the start of treatment

1962a/1965, p. 252
She was therefore over-ripe for this part [the holding part] of the total analytic procedure, though of course needing as much as anyone else does the usual interpretations that become appropriate from day to day, or from minute to minute.

Comment: This is a typical personality feature of borderline personalities, in opposition the schizoid personality, which avoids dependence and shuns regression. Winnicott's total

analytic procedure, or modified analysis, includes management, interpretation and the combination of the two.

7. Diagnosis: borderline schizophrenia

Winnicott does not provide an explicit account of diagnosis. There can be no doubt, however, that this is a case of *psychosis* as defined in his maturational pathology, i.e., a kind of distortion or even blockage of the maturational processes in the stages between birth and the establishment of the I AM position. What kind of distortion? The symptoms and the personality structure suggest borderline schizophrenia. Winnicott uses the term "borderline case" for adult patients who are at core psychotic, that is to say, are split or somehow dissociated since early babyhood, but nevertheless retain enough personality organization, in one stage or another of their life, as defenses against other kinds of disorder, such as psycho-somatic illness or psychoneurosis, in which the central psychotic anxiety threatens to break through in crude form (1968/1989, pp. 219-220). The following general remark from the chapter 23 confirms this view:

> 1962a/1965, p. 256
> [Discussion of the aetiology of disorders that originate in infant-mother relationship which is presented in this paper is] a subject that has great importance because of the fact that one of the growing points of psycho-analysis is in the treatment of the borderline case and in the attempt to formulate a theory of psychotic illness, especially schizophrenia.

Comment: This passage indicates that the whole chapter 23 is an exposition of elements of Winnicott's theory of borderline schizophrenia and that, accordingly, the case of the tortoise dream is an illustration of this kind of pathology. On the theoretical resources provided in this article, see theoretical considerations on pages 258-259 (1962a/1965), and (1963d/1989), chapter 18.

Further readings:

1) The nature of psychosis

> 1963d/1989, p. 90
> It is wrong to think of psychotic illness as a breakdown, it is a defence organisation relative to a primitive agony, and it is usually successful […].

Comment: In the tortoise dream case, it was the primitive agony that prompted the creation of defenses, including the idea of suicide as a defense.

2) How to diagnose?

> 1965b/1989, p. 128
> From the organisation of the defences one gets a clinical picture and the diagnosis is made on the basis of the defence organisation. The defence organisation in turn depends for its characteristics to some extent on a contribution from the environment.

Comment: The defenses show what the environment should have been doing but did not.

3) Difficulties of diagnosing

1959a/1965, p. 132
[…] a patient's diagnosis not only becomes clearer as analysis proceeds but also the diagnosis alters. An hysteric may reveal underlying schizophrenia, a schizoid person may turn out to be the healthy member of an ill family grouping, an obsessional may turn out to be a depressive.

Comment: The diagnosis can change as the patients in real life and in treatment may successively or even simultaneously use different strategies and lines of defense. In this case, the patient changes from a self-holding strategy to an effort to react to a threat of annihilation threat (which was later covered up by a depersonalization strategy). Accordingly, Winnicott's diagnosis changed from false self to a threatened, defenseless and utterly dependent schizoid personality (which later became a borderline schizoid defended by psycho-somatic troubles). See item 14.

8. Etiology of annihilation or breakdown in early babyhood and in the treatment

1) Mother's early unpredictable failures (see above)

1962a/1965, p. 259
[…] the unpredictable external factors did make her ill in her infancy.

Further reading on breakdown:

1962b/1989, p. 75
But as analysts we get involved in the treatment of patients whose *actual clinical breakdowns of infancy* must be remembered by being re-lived in the transference.

1965c/1989, p. 145
At the start trauma implies a breakdown in the area of reliability in the "average expectable environment," at the stage of near-absolute dependence. The result of such breakdown shows in failure or relative failure in the establishment of personality structure and ego organisation.

Comment: Early traumas are produced by the main caring figure, in general the mother.

2) Similar untimely and unpredictable failures of the therapist (Winnicott)

1962a/1965, p. 258
The deficiencies that I am referring to are failures of basic provision – like my going away to the U.S.A. when my patient is not ready for the reactions that occur in her to my going.

Further reading:

1962a/1965, p. 256
The main point is that these failures are unpredictable; they cannot be accounted for by the infant in terms of projection, because the infant has not yet reached the stage of ego-structuring that makes this possible […].

9. Prognosis

1) Increased dependence; uncertainty regarding the development of the case

> 1962a/1965, p. 254
> **(1)** So this patient will be very dependent on me over a phase; the hope is that for her sake, as well as for mine, this dependence will be kept within the confines of the transference and of the analytic setting and sessions. **(2)** But how can one tell in advance? How can one make this sort of diagnosis that is concerned with assessment of needs?

Comment: (1) The prognosis of increased dependence on the therapist is related to the diagnosis that this patient needed to regress to start recovering from the original breakdown on the mother's lap. **(2)** Winnicott hopes it will not spill over into non-analytic settings and that, duly cared for, she will find her way to recovery.

2) Prediction of the need for future failures of the analyst that will in time be induced by the patient

> 1962a/1965, pp. 258-259
> […] I must not fail in the child-care and infant-care aspects of the treatment until at a later stage when *she will make me fail* in ways determined by her past history.

Comment: Forecast of the need to fail the patient's way. This kind of failure is indeed a necessary aspect of a successful treatment process (see Dias, 2011 and Loparic, 2023c). Again, no one can tell what might happen.

10. Setting

Professional. Individual consulting room

11. Therapists

The previous therapist proceeded the traditional way

> 1962a/1965, p. 252
> The patient had had several years of analysis along ordinary lines by an analyst who disallowed regression if this threatened to become acted out and to involve dependence on the analyst.

Later Winnicott and physical doctor acting simultaneously with Winnicott

> 1962a/1965, p. 250
> [The patient's physical illness] was receiving appropriate treatment.

12. Therapeutic relationship

1) With the previous analyst

> 1962a/1965, p. 252
> The patient had had several years of analysis along ordinary lines by an analyst who disallowed regression if this threatened to become acted out and to involve dependence on the analyst.

Comment: The previous analyst prohibited regression, which is an unfavorable attitude, since according to Winnicott regression is the only way to recovery in this kind of case. This clinical point is the foundation of one of the main revolutionary elements in Winnicott's clinical theory.

2) With the physical doctor

> 1962a/1965, p. 250
> Incidentally her physical illness became less of a threat and started to heal, partly of course because it was receiving appropriate treatment.

Comment: The physical treatment of the physical illness, which was a borderline kind of defense against basic threats from the primitive anxiety and the suicidal tendency, was necessary and helpful, but by itself did not stop the patient from using her illness as the organic location of the suicidal tendency.

> 1962a/1965, p. 250
> Actually she […] tends to find doctors of the body to be persecutors.

Comment: In reality, of course, the patient felt persecuted by her suicidal tendency, but this feeling was projected onto the bodily organ and extended to doctors in charge.

3) With Winnicott

On the part of the patient (attitude, behaviour).

a) The need for regressing to dependence in transference was revealed at the very beginning of treatment (see above). In this case, it was not an instinct regression but an ego-regression seeking dependence.

b) Lack of real emotional relationship (anger) with the therapist (see personality structure)

> 1962a/1965, p. 253
> […] you could say that I have caused your illness, just as others have caused you to be ill when you were a baby, and you could be angry. She said: "But I'm not."
>
> […] So I said: "The path is there, wide open for your hatred and anger, but anger refuses to walk down the path."

c) Instead, idealization of Winnicott

> 1962a/1965, p. 249
> Actually she holds me in an idealized position at present […].

Comment: The idealization of Winnicott protected the patient at that stage of treatment from having to acknowledge and deal with his failure, which of course signaled her need of a very deep regression, perhaps including merging with a reliable therapist – which, if and when it happened, would signal the beginning of recovery.

On the part of the analyst meeting regression to dependence.

a) Reliably adapted to the patient's maturational ego needs.

1962a/1965, p. 250
In this case, for instance, the patient became able to cope with my absence because she felt (at one level) that she was now not being annihilated, but in a positive way was being kept in existence by having a reality as the object of my concern.

Comment: This, of course, is an example of the clinical use of cross-identification with the patient (see 1970b/1986, pp. 117-118).

b) Attitude: reliability, trustfulness

1962a/1965, p. 252
The material had been given me in a way that indicated that the patient knew she could trust me not to use it brusquely.

Behaviour: letting things be, waiting for the patient's gesture; adaptation to the patient's need.

1962a/1965, p. 253
The reason why the regressive and dependence dreams have appeared has to do chiefly with her finding that I do not use every bit of material for interpretation, but that I store everything up for use at the right moment and content myself for the present with making preparation for meeting the dependence that is coming up.

1962a/1965, p. 254
The patient told me that the main thing that brought about the very swift, involuntary development towards dependence was the fact that I let things be, and wanted to see what each hour would bring.

Comment: The analyst was opening the potential space-time needed for the patient's spontaneous gesture. Attitude and behavior may be more important to that end than clear understanding or clever interpretation.

Further reading on the analyst's behavior:

1954/1958, p. 286
A good deal more could be said, but the whole thing adds up to the fact that the analyst *behaves* himself or herself, and behaves without too much cost simply because of being a relatively mature person. If Freud had not behaved well he could not have developed the psycho-analytic technique or the theory to which the use of his technique led him. This is true however clever he might at the same time have been. The main point is that almost anyone detail can be found to be of extreme importance at a specific phase of an analysis involving some regression of the patient.

1963c/1965, p. 239
In psycho-analysis the setting is taken for granted. The analyst behaves himself, gives himself over to the patient's interests in the analytic hour […].

4) Limits of the traditional analysis

a) A traditional way of being a bad analyst making good interpretations in such a case

1962a/1965, p. 252
I had plenty of material in this case for the interpretation of the patient's reaction to my going away in terms of oral sadism belonging to love reinforced by anger – anger with me and all the others in her life who have gone away, including the mother who weaned her. I could have

> weighed in, fully justified in terms of what the patient had told me, but then I should have been a bad analyst making good interpretations.

Comment: Here Winnicott restarts discussing the use of interpretation in the treatment of borderline patients. For him, the concept of oral sadism is an important one.

Further reading:

> 1959b/1989, p. 446
> Oral sadism is valuable as a concept because it joins up with the biological concept of hunger, a drive to object-relationships that comes from primitive sources, and that holds sway at least from the time of birth.

Comment: However this concept is not applicable to psychotic patients who need to reclaim or experience for the first time their primary identity in order to keep existing without reacting to environmental turbulence, and who, furthermore, having lost the indwelling in the body (so that their biological drives or instincts are not integrated into their personality) do not lead up to instinctual object-relationships nor to corresponding emotions such as anger and hate.

b) Analysis is provided prematurely

> 1962a/1965, p. 253
> By looking at this bit of material in this way [putting management first], we reach a point where we are discussing both analysis and the meeting of dependence needs. A string of "good" interpretations relative to the general content of the session would produce anger or excitement, and it is not yet possible for this patient to deal with these all-out emotional experiences. It would therefore be bad in the sense of my present statement of analytic procedure to interpret the very things that are relative to the premature separation.

Comment: In this case, an interpretation of the patient's reaction in terms of instinct-based emotional object relations would be bad analysis because of (see above Further reading 2). Moreover, the patient needed help from the therapist to recover from having lost trust in him, not an interpretation of the fact of his going away. In general, at this early stage of treatment, instead of analyses of the content of the materials presented in session, what the patient needs is management that preserves contact and communication.

Further reading:

> 1957/1965, p. 113
> […] the analyst must imaginatively clothe the earliest material presented by the patient with the environment, the environment *that is implied* but which the patient cannot give in analysis because of never having been aware of it.

c) The need to wait for the process of the maturation to reach the appropriate stage

> 1962a/1965, p. 253
> The reason why the regressive and dependence dreams have appeared has to do chiefly with her finding that I do not use every bit of material for interpretation, but that I store everything up for use at the right moment and content myself for the present with making preparation for meeting the dependence that is coming up.

Comment: Doing analysis and meeting upcoming dependences are two different aspects of Winnicott's analytic procedure.

Further reading:

1963b/1965, p. 189
If we wait [to offer interpretation] we become objectively perceived in the patient's own time, but if we fail to behave in a way that is facilitating the patient's analytic process (which is the equivalent of the infant's and the child's maturational process) we suddenly become not-me for the patient, and then we know too much, and we are dangerous because we are too nearly in communication with the central still and silent spot of the patient's ego-organization.

Comment: Untimely interpretation is dangerous because it objectifies the patient and causes inopportune separation and, thus, annihilation.

13. Treatment procedures

Of the previous therapist: ordinary psychoanalysis. As to Winnicott's, he is using his modified analysis combined with management (1962c/1965, pp. 168-169).

14. Treatment process – its dynamics and phases

There is little information about the treatment process. Some data concerning other aspects of the case will be used here under this new perspective to facilitate the exposition.

1) Waiting to start treatment

1962a/1965, p. 249
A young woman patient had to wait for a few months before I could start, and then I could see her only once a week; then I gave her daily sessions […].

Comment: The patient had previously identified the problem that she needed and wanted to treat, namely, her suicidal tendency. This may have helped her to wait.

2) Good reaction to the beginning of treatment

The material reveals a quick regression to dependence, allowed and facilitated by the interest shown by the therapist.

1962a/1965, p. 249
(1) The reaction to the analysis was positive and developments were rapid, **(2)** and I found this independent young woman becoming, in her dreams, extremely dependent.

Comment: (1) The patient developed as the defense of an independent false self collapsed very rapidly in the setting, giving way to extreme dependence on the therapist. **(2)** This was not seen as resistance in the Freudian sense, but as a positive development, being the very condition to begin the recovery of the true self.

3) Initial dream material pointing to a schizoid state of the personality (similar to the one revealed in the tortoise dream; see below)

> 1962a/1965, p. 252
> Very early in the analysis this patient had become represented in her dream material by frail and often maimed creatures, and now she had dreamed of the tortoise with a soft shell.

> 1962a/1965, p. 252 footnote
> By the way, she could also be a horse that had to be shot, else it would have kicked its way out of an aeroplane.

Comment: These all are "regressive and dependence dreams" (1962a/1965, p. 253), a kind of SOS signal in view of the threat of annihilation. Ego regression, not instinct regression, is signaled. The yet unattended maturational need is the basic provision to be achieved by "mental nursing", that is to say, the therapist's care.

4) Winnicott helps the patient's dreaming (see also above)

> 1962a/1965, p. 252
> The reason why the regressive and dependence dreams have appeared has to chiefly with her finding that I do not use every bit of material for interpretation, but that I store everything up for use at the right moment and content myself for the present with making preparation for meeting the dependence that is coming up.

Comment: Winnicott was well adapted to the patient's needs at this phase.

5) On the need of regression to dependence revealed in these dreams

> 1962a/1965, p. 252
> You will have noted that this points the way to a regression to dependence that is bound to come. The patient had had several years of analysis along ordinary lines by an analyst who disallowed regression if this threatened to become acted out and to involve dependence on the analyst. She was therefore over-ripe for this part of the total analytic procedure, though of course needing as much as anyone else does the usual interpretations that become appropriate from day to day, or from minute to minute.

Comment: The dream material signaled the need of dependence to correct the lack of basic provision by the mother and the previous therapist. The patient needed to receive the holding part of the analytic procedure, to which interpretation could and should be gainfully added.

6) Winnicott's trip abroad (USA)

> During one month at the beginning of the intensive phase of the treatment.

> 1962a/1965, p. 249
> […] then I gave her daily sessions just when I was due to go abroad for a month.

Comment: This move is, of course, in agreement with the tradition clinical practice in psychoanalysis, but also reveals the management aspect of Winnicott's total approach.

7) Its traumatic effect: breakdown of the therapeutic relationship

> 1962a/1965, pp. 249-250
> It was in one language as if I were holding her and then became preoccupied with some other matter so that she felt *annihilated*. This was her word for it.

Comment: The language alluded to is, of course, the Winnicottian. The word (not the technical term) "annihilation" came from patients like this and became part of Winnicott's language. This word was already used in a decisive explanation in chapter 3 of (1960b/1965).

8) This effect is a repetition of the original parental trauma (see Facts of the case)

> 1962a/1965, p. 249
> My going away re-enacted a traumatic episode or series of episodes of her own babyhood.
>
> 1962a/1965, p. 256
> The [environmental] deficiencies that I am referring to [as resulting in psychosis, especially schizophrenia] are failures of basic provision – like my going away to the U.S.A. when my patient is not ready for the reactions that occur in her to my going.

Comment: Winnicott's failure seems to have reproduced an original kind of failure by the mother, which did not consist in repression of the patient´s instinctual drives, but in unexpected, unforeseen absence during a period too long for the patient to be able to withstand. Failures like this generate new reaction of defence and can not be used by the patient as positive factors in the process of recovery. On the therapeutic use of therapist´s failures, (see Dias, 2011, chapter 3).

9) Theoretical meaning of Winnicott's failure

> 1962a/1965, p. 249
> Dependence of the patient on the analyst has always been known and fully acknowledged, and for instance shows in the reluctance of an analyst to take on a new patient within a month or two of a long summer holiday. The analyst rightly fears that the patient's reaction to the break will involve deep changes that are not yet available for analysis.

Comment: Like the baby's reaction to failures in the mother's holding, a patient's reactions to failures in the therapist's holding reveal changes in the patient's life that can only be reached and tended to by management, not analysis.

10) The tortoise dream

> 1962a/1965, p. 249
> **(1)** In one dream she had a tortoise, but its shell was soft so that the animal was unprotected and would therefore certainly suffer. **(2)** So in the dream she killed the tortoise to save it the intolerable pain that was coming to it. **(3)** This was herself and **(4)** indicated a suicide tendency, **(5)** and it was to cure this tendency that she had come for treatment.

Comment: (1) In one dream there is a soft-shell tortoise, that is to say, her actual clinical situation is projected on a tortoise unprotected against suffering. However, this dream was more than a projection of inner problems to the external world, a simple visualization of these problems, generated by mental mechanism operation; it was a gesture for the analyst, a personal communication of the state she was in or about to enter, of her utter vulnerability and hopelessness. It was also a readoc with an SOS asking for help, asking him to notice and do something about her feeling unprotected because he – the person on whom she came to depend

so extremely – was absent. **(2)** Explains the kind of suffering that is threatening – intolerable pain or unthinkable anxiety – so that protectively killing the animal was felt by the dreaming patient to be appropriate care. **(3)** Winnicott's interpretation of the dream: the condition of the tortoise in the dream symbolizes the clinical state of the patient by way of projection: once the shell of the false self is abandoned in regression, there is risk (threat) of experiencing intolerable anxiety from extreme vulnerability, from not being able to go on being. **(4)** The killing conjures up a desperate defense established before the defense by the false self, namely, the suicidal tendency in the patient's threatened personality, which, according to **(5)**, was the main symptom that the healthy, self-caring or self-holding part of patient (see below) was trying to get rid of in treatment. See above the dissociation between the urge to live and the urge to die.

11) On the already existing suicidal tendency signaled in the tortoise dream

> 1962a/1965, p. 249
> By killing herself she would gain control over being annihilated while dependent and vulnerable.
>
> 1962a/1965, p. 253
> This dependence phase will be very painful for the patient, and she knows it, and a risk of suicide goes with it, but, as she says, there is no other way.
>
> 1962a/1965, p. 253
> The analyst needs to know why the patient would rather kill himself or herself than live under threat of annihilation.

Comment: Suicidal urge is a way out of the annihilation from the unreliable holding by both the mother and the therapist. The therapist fails the patient from the viewpoint of content (just like the mother), but not from the viewpoint of timing.

12) Psycho-somatic illness as a defensive reaction related to the suicidal urge

The patient's psycho-somatic illness of the borderline kind is an SOS signal and an alternative to suicide as a reaction to the therapist's failure.

> 1962a/1965, p. 250
> The trouble was that she had not yet had time in her analysis to deal with reactions to my going away, and so she had this suicidal dream, and clinically she became physically ill, though in an obscure way.
>
> 1962a/1965, p. 250
> […] and now the physical illness came as a localization in a bodily organ of this total urge to die.
>
> 1962a/1965, p. 253
> […] if her analyst is not able to meet her dependence so that the regression becomes a therapeutic experience, she will break down into psychosomatic illness, which produces the much-needed nursing but not the insight or the mental care that can really make a difference.

Comment: The patient's psycho-somatic illness, the loss the indwelling in the body, was brought about by her weak ego and used as a cover-up for her previously existing suicidal urge, which was reignited by the therapist's failure – repeating the parental failure – but was

also a way of recovering from it. This explains why physical treatment was beneficial, but not enough to cure the patient. The original problem was not the indwelling in the body, but the annihilation of the unit self.

13) Winnicott's correction of his failure

> 1962a/1965, p. 250
> Before I went I just had time, but only just, to enable her to feel a connexion between the physical reaction and my going away.
>
> 1962a/1965, p. 250
> She felt helpless about this until I was able to interpret to her what was happening, whereupon she felt relief, and became able to let me go.

Comment: Winnicott says "feel", not "understand". Interpretation felt as relief.

14) The nature of the provided interpretation

> 1962a/1965, p. 250
> **(1)** The amazing thing is that an interpretation can bring about a change, and one can only assume that understanding in a deep way and interpreting at the right moment is a form of reliable adaptation. **(2)** In this case, for instance, the patient became able to cope with my absence because she felt (at one level) that she was now not being annihilated, but in a positive way was being kept in existence by having a reality as the object of my concern. **(3)** A little later on, in more complete dependence, the verbal interpretation will not be enough, or may be dispensed with.

Comment: In **(1)**, interpretation is viewed as a form of needed therapeutic care. This is exemplified in **(2)**. In **(3)**, new forms of care are said to be necessary, namely, management.

15) More about the ego-assessing and the ego-adaptive direction: reliance on cross identification or total response

> 1962a/1965, p. 250
> In innumerable ways we meet our patient's needs because we know what the patient is feeling like, more or less, and we can find the equivalent of the patient in ourselves. What we have in ourselves we can project, and find in the patient.

Comment: This, of course, is a direct allusion to the therapist's capacity for cross identification, which is the "the ability of one individual to enter imaginatively and yet accurately into the thoughts and feelings and hopes and fears of another person" (1970a/1989, p. 117). In this particular case, a well-trained Winnicottian analyst would understand that "we must avoid going away just after starting an analysis" (1962a/1965, p. 250).

Further reading: *Parental care as the model for therapeutic cross-identification with the patient*

> 1962a/1965, p. 251
> In a deliberate examination of the external factor, I am thus far engaged in relating the analyst's personality, capacity for identifying with the patient, technical equipment, and so on, to the multifarious details of child-care, and then in a more specific way to the special state that a

mother is in (perhaps father also, but he has less opportunity to show it) in the short time-space covering the later stages of pregnancy and the first months of the infant's life.

16) Winnicott's comment on the two possible ways forward in treatment

a) The traditional way: instinct-based treatment

1962a/1965, p. 250
You will have observed that I could go in either of two directions, starting from such a fragment from an analysis. One direction would take us to the analysis of reaction to loss and so to the main part of that which we learn in our psycho-analytic training. […] This other direction takes me to the understanding we have in us that makes us know that we must avoid going away just after starting an analysis. It is an awareness of the vulnerability of the patient's ego, the opposite of ego-strength.

Comment: There are two ways of understanding the analysis of the patient's reaction to Winnicott going away: either as a reaction to the loss of somebody to whom the patient is related in terms of instinctual object relations (in keeping with the teachings of traditional analysis) or as the ego support needed due to the therapist's failure in meeting the recently initiated regression to (absolute) dependence (in keeping with Winnicott's maturational pathology).

b) When the instinct-oriented direction of treatment turns into bad analysis

1962a/1965, p. 252
I had plenty of material in this case for the interpretation of the patient's reaction to my going away in terms of oral sadism belonging to love reinforced by anger – anger with me and all the others in her life who have gone away, including the mother who weaned her. I could have weighed in, fully justified in terms of what the patient had told me, but then I should have been a bad analyst making good interpretations. I should have been a bad analyst because of the way the material had been given me.

Comment: Although some aspects of the traditional interpretation of the material would not be baseless, it would nevertheless be wrong and counterproductive, and therefore bad.

Further readings:

1) Ego-needs, Id-needs and integration for Id-needs in the personality structure

1960c/1965, p. 141
It must be emphasized that in referring to the meeting of infant needs I am not referring to the satisfaction of instincts. In the area that I am examining the instincts are not yet clearly defined as internal to the infant. The instincts can be as much external as can a clap of thunder or a hit. The infant's ego is building up strength and in consequence is getting towards a state in which id-demands will be felt as part of the self, and not as environmental.

2) An example of bad use of the traditional analysis based on instincts

1960a/1984, p. 85
I am thinking here of the treatment of a woman. Early in the treatment I made a mistake which nearly ended everything. I interpreted this very thing, oral sadism, the ruthless eating of the object belonging to primitive loving. I had plenty of evidence, and indeed I was right, but the interpretation was given ten years too soon. I learned my lesson. In the long treatment that followed, the patient reorganized herself and became a real and integrated person who could accept the truth about her primitive impulses. Eventually she became ready for this interpretation after ten or twelve years of daily analysis.

Comment: See the quotation in (1954/1958, pp. 279-280) above.

3) Danger of ignoring dissociation

1971/2017, p. 355
In time we may have to come to the conclusion that the common failure of many excellent analyses has to do with the patient's dissociation hidden on material that is clearly related to repression taking place as a defence in a seemingly whole person.

c) Why would the instinct-oriented direction of the treatment be bad?

1962a/1965, p. 251
By looking at this bit of material in this way, we reach a point where we are discussing both analysis and the meeting of dependence needs. A string of 'good' interpretations relative to the general content of the session would produce anger or excitement, and it is not yet possible for this patient to deal with these all-out emotional experiences. It would therefore be bad in the sense of my present statement of analytic procedure to interpret the very things that are relative to the premature separation.

Comment: In the treatment of very early disorders related to privation, management comes first, and only later interpretation. Moreover, interpretation in terms of bodily and instinctual emotions is meaningless.

d) Need to take a revolutionary step and recognize external etiological factors in analysis, in addition to internal mechanisms

1962a/1965, p. 251
Psycho-analysis has stood for the personal factor, the mechanisms involved in individual emotional growth, the internal strains and stresses that lead to the individual's defence organization, and the view of psycho-neurotic illness as evidence of intrapsychic tension that is based on id-drives that threaten the individual ego. But here we return to ego vulnerability and therefore to dependence.

Comment: Psychotic cases cannot be treated as disorders of the Freudian psychic apparatus. It might be admitted, of course, that this patient is healthy (mature) enough to use mental mechanisms (e.g., projection of her problems onto an dream figure such as the tortoise), but it should be also recognized that her need for protection (implying a need for regression) was not *mentally projected* as such, but merely *transferred* – and, therefore, is visible only to a therapist trained in maturational analysis, remaining outside the manifest content (and even of the thought-content) of the tortoise dream and, thus, out of reach of the patient's intellectual or felt awareness.

e) Need for changes in psychoanalytic training: enablement of a *good-enough analyst*

1962a/1965, p. 251
If we accept the idea of dependence, then we have already started to examine the external factor, and indeed when we say an analyst should be trained we are saying that an essential for orthodox psycho-analysis is an external factor, that is to say the *good-enough analyst*.

Further reading: Training in the modified (maturational) analysis

1959c/1965, p. 163
If a significant change is to be brought about the patient will need to pass through a phase of infantile dependence. Here again psycho-analysis cannot be taught, though it can be practised in modified form. The difficulty here is in diagnosis, in the spotting of the falseness of the false personality which hides the immature true self. If the hidden true self is to come into its own in such a case the patient will break down as part of the treatment, and the analyst will need to be able to play the part of mother to the patient's infant. This means giving ego-support in a big way. The analyst will need to remain orientated to external reality while in fact being identified with the patient, even merged in with the patient. The patient must become highly dependent, even absolutely dependent, and these words are true even when there is a healthy part of the personality that acts all along as an ally of the analyst and in fact tells the analyst how to behave.

Comment: There is a clear similarity between this 1959 text and chapter 23 written in 1962 (1959c/1965 e 1962a/1965).

f) Hint to accepted revolutionary changes in some of Freud's views

1962a/1965, p. 251
All this is self-evident, yet I can still find those who *either* never mention this external factor as if it were really important, *or* else talk about it all the time, ignoring the internal factors in the process. As Zetzel said in a seminar recently: first Freud thought all neurotic persons had had sexual traumata in childhood, and then he found that they had had wishes. And then for several decades it was assumed in analytic writings that there was not such a thing as a real sexual trauma. Now we have to allow for this too.

Comment: In Winnicott's time, and even today, a large portion of the psychoanalytic community was far from taking his views as evident or being ready to agree with them.

g) Pattern of the next sessions conducted in terms of Winnicott's maturational analysis

1962a/1965, p. 254
(1) Actually the pattern had been that she would start almost as if the hour were a social visit. She would lie down and display very clear intellectual awareness of herself and of her surroundings. **(2)** I played in with all this, and there was much silence. **(3)** Near the end of each hour she would quite unexpectedly remember a dream, and she would then get my interpretation. The dreams presented in this way were not very obscure, **(4)** and the dream resistance could usually be seen to reside in the forty-five minutes of material that preceded it and that was not good material for interpretation. **(5)** That which has been dreamed and remembered and presented is within the capacity of the ego-strength and structure.

Comment: (1) Sessions began almost like a social visit, with conscious control and the false self in charge, which is a typical borderline defensive attitude against schizoid threats. **(2)** Winnicott participates (plays in) but does not interpret (see **(4)**). He mostly keeps silent. This is a liberated space-time for revealing dreams. **(3)** These come suddenly, like the tortoise dream, and are interpreted. **(4)** Resistance to dreaming is overcome. That is, she has overcome her resistance to facing the potentially distressing (and, therefore, threatening) material of the ego's organization that will be revealed in the dream. **(5)** This shows that, in treatment, the limits of the ego-strength have been acknowledged and respected. This pattern is an example of what takes place in Winnicott's "modified analysis" of psychotic patients: management, followed by

timely and properly articulated interpretation. As interpretation may become unnecessary or even dangerous, a suggestion is that this be called "maturational analysis".

15. Therapeutic results

Only very few partial results are reported.

1) A small temporary increase in personal strength to cope with absence of the person on whom she was dependent for an extended period of time

> 1962a/1965, p. 250
> She felt helpless about this until I was able to interpret to her what was happening, whereupon she felt relief, and became able to let me go.

> 1962a/1965, p. 250
> In this case, for instance, the patient became able to cope with my absence because she felt (at one level) that she was now not being annihilated, but in a positive way was being kept in existence by having a reality as the object of my concern.

2) Beginning of psycho-somatic recovery by way of both the maturational and the physical therapist

> 1962a/1965, p. 250
> Incidentally her physical illness became less of a threat and started to heal, partly of course because it was receiving appropriate treatment.

3) The actual achievement of regression to personal dependence on the therapist remains uncertain.

This would have meant the beginning of the patient's recovery from borderline schizophrenia through her previous recovery from the annihilation of the "going on being" and from the breakdown in the establishment of the unit self. See "Prognosis" above).

16. Case summary

> 1962a/1965, p. 258-259
> **(1)** Finally, in regard to the patient to whom I have referred, I must not fail in the child-care and infant-care aspects of the treatment until at a later stage when *she will make me fail* in ways determined by her past history. **(2)** What I fear is that by giving myself the experience of a month abroad I may have already failed prematurely and have joined up with the unpredictable variables of her infancy and childhood, so I may have truly made her ill now, as indeed the unpredictable external factors did make her ill in her infancy.

Comment: (1) Winnicott applies to the case his thesis that the therapist must fail in the patient's way, not generate new traumas and allow the original environmental (maternal) trauma to be reached at the right moment of the patient's clinical history. **(2)** He recaps the essential dynamics of the entire case, both in early life and during treatment.

17. Theoretical results

This case is a research report of clinical material used by Winnicott when elaborating his radically new theoretical and clinical theses on the nature (diagnostic) and etiology of psychosis (like for instanceborderline schizophrenia), and on treatment through dependence and psychotic transference within a modified version of analysis that combines management and interpretation. It throws light on the distance separating Winnicott's paradigm from that of traditional psychoanalysis and helps us understand the meaning of his plea, formulated a few days before he died, for a revolution in psychoanalytic clinical practice.

18. Follow-up

No data.

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