BOLETIM WINNICOTT NO BRASIL, Area IWA, Section Comments, 2023/07/26

A Commentary on Chapter 23, "Dependence in infant-care, in child-care, and in the psycho-analytic setting" of Winnicott's The Maturational Processes and the Facilitating Environment

Z. Loparic
IBPW/IWA

Introduction

This text is an annotated *structural analysis* of chosen theoretical paragraphs of Chapter 23, "Dependence in infant-care, in child-care, and in the psycho-analytic setting", of *The Maturational Processes and the Facilitating Environment*. This kind of commentary is intended for students committed to reading Winnicott and to writing on Winnicott. It can serve, in particular, as a template for producing similar commentaries. Careful study of texts is a prerequisite for doing science. The position of a student undergoing scientific training can be compared, says Winnicott, to that of a cellist, who "first slogs aways at *technique* and then actually becomes able to play *music*" (1971b, p. 6). Being creative in science, in art form or in philosophy depends very much "on the study of all that exists already" (1970/1986, p. 53).

To be fruitful at an advanced level, the study of Winnicott's scientific texts should, in my view, heed their structural elements, including: bibliographical and other data about the manuscript and the published versions of the text, the intended audience, the objectives, the content (main groups of topics discussed), the order the topics are presented, their logical connections, and the place of the text in Winnicott's writings. To attain an overall view of these elements, one must examine the successive formulations of the results of Winnicott's revolutionary research toward a new scientific paradigm for psychoanalysis and other fields of healthcare dedicated to the study and treatment of maturational disorders.

The main structural features of Winnicott's article will be given titles in bold and subtitles in italics. Capital letters in bold (**A**, **B**…) will mark all quotations commented upon. The main points of each quotation will be indicated by bracketed numbers in bold ((**1**), **(2)** …) and comments on these points will be identified likewise ((**1**), **(2)** …). In this manner, the commentaries can be as precise, detailed and complete as desired, and I hope readers will find this helpful.

1. The text and its intended audience

The text was published in 1963 as the last chapter of *The Maturational Processes and the Facilitating Environment* and is based on a paper delivered by Winnicott at the Boston Psychoanalytic Society in 1962. That might be the reason why the title and certain statements refer specifically to dependence in the psychoanalytic setting, whereas the text itself also considers the non-psychoanalytic familial setting (see below). In other writings, Winnicott also addresses very different kinds of audiences outside psychoanalysis, from medical doctors, psychologists, social workers and teachers to parents and representatives of healthcare and educational institutions.

2. The objective: the study of dependence in treatment and in early family life

A 1963/1965, p. 257
My general objective is to relate dependence in the psycho-analytic transference to dependence at various stages of infant-and child-development and care.

Comments: Overall, Chapter 23 focuses on one point of the summary in Chapter 3 (see 1960a/1965, p. 55), which presents a guideline to understand the whole book: 1) the main feature of infancy and childhood (and, in different degrees, of all periods of an individual's life circle) is dependence on the holding environment; 2) a good enough holding environment facilitates the maturational processes along their main lines and a not good enough one distorts or even blocks them; 3) these two aspects of the holding environment may or may not appear in transference if, at a later date, the infant should go into treatment. This last point is the main topic of Chapter 23. Children differ from babies by new maturational achievements and require new kinds of care both in health and ill-health, corresponding to different kinds of dependence in transference: psychotic transference, antisocial transference and, indirectly, psycho-neurotic transference as well (see below).

B 1963/1965, p. 257
(1) There is nothing 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. **(2)** What I feel may need restating from time to time is the relationship between these two examples of dependence.

Comments: (1) The idea of dependence is a matter of course for pediatricians and child psychiatrists and is becoming well-known to analysts. **(2)** The restatement is needed because of advances in research, one example of which is the theory of the therapeutic use of the therapist's failures, discussed at the end of the chapter.

Further reading:

1. Key place of the word "dependence" in Winnicott's vocabulary

> **C** 1963/1965, p. 257
> **(1)** The key word in this part of the study is *dependence*. Human infants cannot start to *be* except under certain conditions. […] **(2)** This [potential] is inherited, and it is legitimate to study this inherited potential of the individual as a separate issue, *provided always that it is accepted that the inherited potential of an infant cannot become an infant unless linked to maternal care*.

Comments: (1) The "being" of human individuals only starts in the relationship of dependence on other, already existing, human beings. Initially, "being" means basically being in contact, relating to the initial environment and, in it, to other human individuals who are already there existing in a more mature way. **(2)** Explains that the main aspect of environmental provision for healthy development of the potential to be is *care*, initially provided by the mother.

2. Dependence: changes from Freud to Winnicott

> **D** 1963/1965, pp. 133-134
> **(1)** It is being recognized in the last few years that […] it is necessary for the analyst first of all to provide conditions which will allow the patient to hand over to the analyst the burden of the internalized environment, and so to become a highly dependent but a real, immature, infant; then, and then only, the analyst may analyse the true self. **(2)** This could be a present-day statement of Freud's *anaclitic dependence* in which the instinctual drive leans on the self-preservative. Dependence of the schizoid patient or of the borderline case on the analyst is very much a reality, so much so that many analysts prefer to avoid the burden and they select cases carefully.

Comments: (1) Winnicott has psychotic patients in view. **(2)** It should be noted that Freud's anaclitic dependence is an entirely different biological concept: it refers to the conservation instinct and does not involve communication with the patient's true self. Winnicott's "present-day" reformulation is a tacit admission of a very significant paradigm shift occurring in his thought at that time (early 1960s), See 1960a/1965 and Dias, 2022.

3. Failure to meet dependence in treatment

1) The main theme of the chapter

> **E** 1963/1965, p. 257
> **(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.

Comments: (1) It is neither necessary nor enough to quote from Freud. **(2)** The relationship between dependence in early life and in professional therapeutic settings is not, strictly speaking, psychoanalytic, as the problem of dealing with dependence has been recognized since the beginning of medical practice. **(3)** Disturbance of the relationship of dependence implies deep existential changes, both in early human life and in treatment, and are produced in the psychotic patient by a breach in the transference relationship caused by failures of the therapist that overwhelm the patient. These changes cannot be treated by psychoanalytic analysis, and must be dealt with by other procedures, as will be shown. **(4)** The article will begin by presenting an example of the deep changes (from such a breach) in the clinical state of the patient who dreamt of a tortoise.

2) Illustrative case

a) Some clinical facts of the case

> **F** 1963/1965, p. 249
> **(1)** 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 **(2)** just when I was due to go abroad for a month. **(3)** The reaction to the analysis was positive and developments were rapid, and I found this independent young woman becoming, in her dreams, extremely dependent.

Comments: (1) The patient obviously wanted analysis, which was delivered in the format of ordinary weekly sessions**. (2)** Then there was a break, related to Winnicott's personal affairs, that in certain measure meant he was letting the patient down. **(3)** Prior to the failure, the patient underwent extreme regression to dependence on the therapist, as revealed in dreams, heralding the quick start of the recovery.

b) The tortoise dream

> **G** 1963/1965, 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 indicated a suicide tendency, and it was to cure this tendency that she had come for treatment.

Comments: The therapist's trip abroad meant the breakdown of the therapeutic relationship. The exact nature of the failure and of the ensuing trauma will be discussed later. **(1)** The patient reacted strongly to the breakdown and the very painful changes that occurred in her clinical state are revealed in a mental projection (a dream) from the patient to the outside world (the tortoise). **(2)** Killing the tortoise meant suicide, which was the patient's defense projected against the breakdown and the extreme and unthinkable anxiety and suffering (Winnicott becomes more technical and precise here). **(3)** The first, partial (implicit) diagnosis was: the idea of suicide that emerged in

treatment reveals suicidal tendency, which was also the patient's original defensive move against the unthinkable agony resulting from the original breakdown caused by her mother's pattern of failures (see below).

c) Patient's automatic defense reactions

> **H** 1963/1965, p. 249
> 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.

Comments: In treatment, to the defensive dream, produced by the mental mechanism of projection, were added new bodily symptoms of a psycho-somatic illness, amounting to a pre-mental defense organization: depersonalization, the disturbance of the indwelling in the body.

d) Interpretation: diagnosis and etiology of psycho-somatic symptoms

> **I** 1963/1965, pp. 249-250
> **(1)** Before I went, I just had time, but only just, to enable her to feel a connexion the physical reaction and my going away. My going away re-enacted a traumatic episode or series of episodes of her own babyhood. It was in one language as if I were holding her and then became preoccupied with some other matter so that she felt *annihilated.* This was her word for it. **(2)** By killing herself she would gain control over being annihilated while dependent and vulnerable. In her healthy self and body, with all her strong urge to live, she has carried all her life the memory of having at some time had a total urge to die; and now the physical illness came as a localization in a bodily organ of this total urge to die. **(3)** She felt helpless about this until I was able to interpret to her what was happening, where upon she felt relief, and became able to let me go. **(4)** Incidentally her physical illness became less of a threat and started to heal, partly of course because it was receiving appropriate treatment.

Comments: (1) Winnicott's interpretation of the patient's psycho-somatic symptoms is that they are: a) related to his going away, that is to say, to his failure in treatment, which overwhelmed the patient, b) a repetition of pre-sexual, disturbing body-related episodes in babyhood in the now disturbed body functioning, c) not a sexually motivated hysterical reaction, and d) revelatory of earlier failures in the mother's holding, now repeated by Winnicott's failure to provide reliable holding in the setting. These symptoms signal not only a disturbance of the functioning of a body organ, but also, and more significantly, the threat of disintegration, of a kind of depersonalization, of the breakdown of the personality structure. Importantly, the tortoise dream and the psycho-somatic disturbances are results not of internal conflicts regarding the management of instincts, but of the relationship of dependence on the therapist during treatment. **(2)** Killing (suicide) meant, paradoxically, an attempt to gain of control over a painful personality split, over both kinds of symptoms: the total urge

to live and the urge to finally die. **(3)** Winnicott's maturational interpretation is welcomed and effective. **(4)** Partial somatic recovery.

e) Winnicott's correction of his failure. Interpretation as care.

> **J** 1963/1965, p. 250
> **(1)** If illustration were needed this might show the danger of underestimating transference dependence. 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.

Comments: (1) Theoretical comments on the effectiveness of the right kind of interpretation start here. **(2)** What did interpretation do in this case? It did not decode the repressed unconscious, but rather delivered a deep understanding at the right moment, when a reliable ego-strengthening adaptation was needed. **(3)** This is a theoretical aspect of Winnicott's *total therapeutic procedure*: interpretation may be necessary and effective at a certain stage of treatment, but is not sufficient and may even be dispensed with and fully substituted by management (see details below).

4. Interpretation or care: paradigm shift from traditional analysis to Winnicott's total response procedure

1) The two alternatives for the continuation of treatment

At this point, Winnicott reflects on whether to continue treatment by traditional analysis of internal factors, that is, of inner conflicts of whole persons related to the satisfaction of instinctual needs, or by management of ego-needs combined with maturational analysis, taking into account external etiological and therapeutic factors.[1]

> **K** 1963/1965, p. 250
> **(1)** 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. The other direction takes us to that which I wish to discuss in this paper. **(2)** 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. **(3)** It is an awareness of the vulnerability of the patient's ego, the opposite of ego-strength. **(4)** 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. **(5)** All this is done silently, and the patient usually remains unaware of what we do well, but becomes aware of the part we play when things go wrong. It is when we fail in these respects that the patient reacts to the unpredictable and suffers a break in the continuity of his going-on-being. **(6)** I wish to take up

[1] On the difference between ego and id needs, see Winnicott, 1960c/1965, p. 141.

this point in particular later on in this paper, in discussing Zetzel's Geneva Congress paper (1956).

Comments: (1) Possible directions of treatment: either the conventional one, as taught in traditional psychoanalytic training, or the new, Winnicottian one, to be discussed in the chapter. **(2)** Importance of being aware of the etiological relevance of the therapist's attitude, that is to say, of the role of external factors in the etiology of maturational disorders. **(3)** Attention to the vulnerability of the patient and to her ego strength or weakness, that is to say, to the strength or weakness of the integration she achieved, not to her possible inner conflicts. **(4)** Treatment of ego-needs based on cross-identification (but not named as such), as part of Winnicott's total response procedures (on this expression, see 1960b/1965, p. 164). **(5)** On the traumatic effect of the therapist's unpredictable failures that interrupt the patient's going-on-being and replicate the original breakdown caused by the mother. **(6)** The traumatic nature of the failures of both parents and of the therapist will be discussed later on in the paper.

2) More on the difference between traditional and Winnicottian etiology. Examples of the paradigm shift.

> **L** 1963/1965, pp. 250-251
> **(1)** You will see that I am involved in an attempt to evaluate the external factor. **(2)** May I be allowed to do this without being thought to be going back on what psycho-analysis has stood for over the past forty years in child psychiatry. **(3)** 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. **(4)** But here we return to ego vulnerability and therefore to dependence.

Comments: (1) Explicitly introduces one major point of the paper: etiology based on external factors rather than on internal ones. **(2)** Announces radical changes vis-à-vis the orthodox theory of etiology in psychoanalysis and child psychiatry. **(3)** The personal factor and internal conflicts. traumatic factors in traditional psychoanalysis. Etiology based on inner conflicts. **(4)** External factors related to vulnerability and dependence.

3) Problems with the paradigm shift

a) State of the psychoanalytic study of external factors

> **M** 1963/1965, p. 251
> **(1)** It is easy to see why it is that psycho-analysts have been reluctant to write about the environmental factor, since it has often been true that those who wished to ignore or deny the significance of the intrapsychic tensions chiefly stressed the bad external factor as a cause of illness in child psychiatry. **(2)** However, psycho-analysis is now well established, and we can afford to examine the external factor both bad and good.

Comments: (1) Winnicott explains that the reactionary position of orthodox psychoanalysis is based on two assumptions mistakenly attributed to the advocates of the etiological relevance of external factors, none of which he shares: 1) the wish to

ignore or deny the significance of intrapsychic conflicts, and 2) real or imputed emphasis on *bad* external factors (see analysis of Zetzel's statement below). Both features are absent in Winnicott's proposal. **(2)** Psychoanalysis is now (1962) a mature enough scientific discipline to be able to undergo a revolutionary change without being destroyed.

b) Training of a good enough analyst is a requirement even of orthodox psychoanalysis

> **N** 1963/1965, p. 251
> **(1)** If we accept the idea of dependence, then we have already started to examine the external factor, and **(2)** 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.* **(3)** 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.

Comments: (1) If we accept the ideas that a) the human infant can only develop its inherited potential and become a healthy individual through relationships of dependence on a facilitating human environment, and b) ill-health in early life results from environment's failure to provide the facilitation needed at that age, we are already considering good and the bad external factors. **(2)** These ideas are, of course, very relevant to clinical practice, and also to the training of analysts, even in orthodox psychoanalytic schools, although **(3)** they are systematically ignored or made trivial and, thus, irrelevant.

c) The therapist's personality structure as an external factor

> **O** 1963/1965, 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.

Comments: Asserts the central role of the capacity for cross-identification in Winnicottian clinical practice and its relation to parental childcare.

d) Parental model for dealing with external factors

> **P** 1963/1965, pp. 251-252
> Psycho-analysis as we learn it is not at all like child-care. In fact, parents who interpret the unconscious to their children are in for a bad time. But in the part of our work as analysts that I am referring to there is nothing we do that is unrelated to child-care or to infant-care. In this part of our work we can in fact learn what to do from being parents, from having been children, from watching mothers with very young babies or babies unborn, from correlating parental failures with subsequent clinical states of ill children.

Comments: A fundamental statement: psychoanalysis as taught in traditional psychoanalytic schools is different both from what one learns from parents and from what is taught today in Winnicottian schools.

e) Preview of two future comments in the chapter on psycho-neurosis and corrective experience

> **Q** 1963/1965, p. 252
> **(1)** While we know that psycho-neurotic illness is not caused by parents, we also know that the mental health of the child cannot become established without good enough parental or maternal care**. (2)** We also know that a corrective environmental experience does not directly cure the patient any more than a bad environment directly causes the illness structure. I refer to this again at the end of this paper.

Comments: (1) Neurosis is not directly dependent on the environment, while the acquisition of mental health and the prevention of psychosis are. **(2)** Anticipates what will be said at the end of the paper, after discussing psycho-neurotic illnesses and corrective environmental experiences with Zetzel.

f) Providing bad treatment by making good interpretations of instinctual impulses

> **R** 1963/1965, p. 252
> **(1)** 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. **(2)** 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.

Comments: (1) This alludes to the discussion of the two parts of Winnicott's total treatment procedure: interpretation and treatment of instinctual troubles and their elaboration by mental mechanisms, on the one hand, and meeting the regression to dependence, on the other. **(2)** Theoretically, in the tortoise dream case there is the possibility of traditional interpretation from the very start. Yet, this would be a clinically bad thing to do in the early stages of treatment, because dependence is the dominant feature.

g) Dangers of bad analyses in general

> **S** 1963/1965, p. 253
> **(1)** 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. **(2)** […] if her analyst is not able to meet her dependence so that the regression becomes a therapeutic experience, she will break down into psycho-somatic illness, which produces the much-needed nursing but not the insight or the mental care that can really make a difference. The analyst needs to know why the patient would rather kill himself or herself than live under threat of annihilation.

Comments: (1) In Winnicott's analysis, impending dependence is very painful, for the patient is approaching his/her original breakdown, bringing with it the risk of

suicide, but is made tolerable by being met by the therapist. **(2)** If regression is not attended to and does not lead to recovery, psycho-somatic illness becomes an alternative to suicide.h) Need to accept new discoveries, some of them correcting Freud

> **T** 1963/1965, p. 251
> 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.

Comments: External sexual factors have to be admitted, going against Freud's explicit denial of their etiological relevance in the second version of his seduction theory (which, by the way, has revealed itself very damaging for the development of psychoanalysis).

i) Application to the present case

> **U** 1963/1965, p. 253
> **(1)** 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. **(2)** A string of 'good' interpretations relative to the general content of the session would produce anger or excitement, and **(3)** it is not yet possible for this patient to deal with these all-out emotional experiences. **(4)** 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.

Comments: (1) Analysis should be combined in due time with holding, the meeting of integration needs. **(2)** If done badly, traditional analysis would produce anger; if done well, it would generate excitement. **(3)** In the present case, traditional analysis would produce neither of these effects, because the patient's ego was not capable of accommodating strong emotions such as anger and excitement.[2] **(4)** Therefore, it is a bad analysis to interpret rather than manage clinical data related to problems stemming from the premature separation of the baby from the mother.

5. Dependence in childcare and in the treatment of childhood problems

1) General aspects of child care

There follows in the chapter a discussion of dependence in childcare, a case, the identification of the case as belonging to child psychiatry, and an observation connecting parental management and psychoanalytic treatment.

> **V** 1963/1965, p. 254
> In terms of *child-care,* I would like to exemplify regression in the service of the ego by looking at the phases of spoiling which parents find one child needs from time to time-parents, that is, who do not spoil their child because of their own anxieties. Such phases of spoiling bring many

[2] For a study of this feature of the case, see Loparic, 2023.

> a child through without any involvement of a doctor or a child guidance clinic. It is difficult to give a case without making it sound rare, and these are matters of common experience in family life, when parents care for their own children. For a few hours, or days, or weeks, in a special context, a child is treated as if of a younger age than is in fact true chronologically. Sometimes it happens when a child bangs his head or cuts his finger; he goes in a moment from four to two, and is screaming and consoling himself with his head in his mother's lap. Then in no time, or after a sleep, he is again very grown up, and more so than his own age warrants.

Comments: Winnicott starts discussing the parallels between dependence in child-care and in treatment of maturational processes distorted in childhood and presents a general overview of symptomatology.

2) A case

a) Environmental failure and antisocial symptoms

> **X** 1963/1965, pp. 252-253
> **(1)** Here is a boy of two (Winnicott, 1963). He reacted very badly at twenty months to the mother's anxiety which she experienced when she conceived. It is part of her pattern to become extremely anxious at conception. **(2)** He stopped using the pot and stopped using words, and his forward progress was held up. When the baby was born he was not hostile to the baby, but he wanted to be bathed like the baby. At breastfeeding time he started thumb-sucking, which had not previously been a feature. **(3)** He made special claims on the parents' indulgence, needing to sleep in their bed for many months. His speaking was delayed.

Comments: (1) Etiology: the mother deprives the child because of her personal difficulties with a new pregnancy. **(2)** These symptoms reveal instinctual regression. **(3)** Further symptoms reveal social and mental regression.

b) Dynamics and phases of treatment by parents acting as therapists in the family setting.

> **W** 1963/1965, p. 255
> **(1)** The parents met all these changes and demands in a satisfactory way, but the neighbours said that they were spoiling the boy. **(2)** Eventually the boy emerged from his regression or withdrawal and the parents were able to finish with spoiling him when he was eight years old, **(3)** after he had had a phase in which he was stealing money from them.

Comments: (1) "Regression by spoiling" is successfully provided by parents, without the need for medical help. **(2)** Phases of spoiling. **(3)** At the end, emergence of symptoms allowing a diagnosis of antisocial tendency (which, however, is left implicit). On diagnosis, see observation on deprivation, 1963/1965, p. 257, and my comments below.

6. Reflections on child psychiatry

1) First management, then interpretation

> **Y** 1963/1965, p. 255
> **(1)** This is a common type of case in child psychiatry, as I know it, especially in private practice when children are brought for symptoms that in child guidance might be considered to be

> insignificant. **(2)** It has been an important part of my child psychiatry orientation to recognize that in such a case one does not immediately think of psycho-analysis; one thinks of supporting these parents in their management of their child's babyishness. One may be in a position, of course, to give psycho-analytic help, while the parents are carrying out the mental nursing of the patient, but it is a formidable matter to treat such a case by psycho-analysis if there is not a parental provision that will meet the mental nursing needs. **(3)** Without the parents' mental nursing the psycho-analyst doing psycho-analysis must find the patient not only dreaming of being taken over by the analyst and into his or her home, but also actually needing to be taken in.

Comments: (1) These are typical cases that come up in Winnicott's private practice and allowed him to identify and collect symptoms that were not valued in other settings (e.g., the child guidance of the time) and to formulate his new theoretical views in child psychiatry. **(2)** Appreciation of the therapeutic value of parental management, which may be profitably helped by the Winnicottian kind of psychoanalysis. **(3)** On certain advantages of family practice over traditional psychoanalysis in general (in some cases Winnicott was not successful in taking a child patient to his home[3]). Hence the need to theoretically admit and to welcome treatments based on childcare and not only on psychoanalysis. Winnicott's view is explained more fully below.

2) Theoretical implications

> **Z** 1963/1965, p. 255
> A corollary of this is that when an orthodox psycho-analysis of a child is successful there is an acknowledgement to be made by the psycho-analyst that the parent's home, relations, helpers, friends, etc., did nearly half the treatment. We do not have to make these acknowledgements out loud, but we need to be honest about these matters of the patient's dependence when we are theory-building.

Comments: In the treatment of antisocial cases, the therapist's failure is not therapeutically useful, since, by hypothesis, there was no breakdown in the early stages and the unthinkable anxiety that results from deprivation is only a temporary clinical phenomenon that fades away when a reliable and non-retaliatory environment is secured offering opportunities for recovery. In the treatment of borderline and schizoid cases, however, the therapist's failures that correspond to what the patient needs are an integral part of treatment (see Dias, 1994/2011).

7. Discussion with Zetzel on the nature of early traumas

1) Zetzel's views

After discussing dependence in childcare, the corresponding disturbances, and their treatment in child psychiatry, Winnicott goes back to dependence in infant care and discusses the etiology of these disturbances by commenting on a paper by Zetzel where she refers to his

[3] See 1947/1958.

views. During his stay in Boston for the presentation of his paper Winnicott was received by Zetzel at her place.

> **AA** 1963/1965, p. 255
> Here I wish to refer to a paper by Zetzel (1956). […] She writes: "Other analysts – Dr. Winnicott, for example – attribute psychosis mainly to severe traumatic experiences, particularly of deprivation in early infancy. According to this point of view, profound regression offers an opportunity to fulfil, in the transference situation, primitive needs which had not been met at the appropriate level of development. Similar suggestions have been proposed by Margolin and others...".

Comments: Zetzel (erroneously, see below) ascribes to Winnicott the view that psychosis results from "severe traumatic experiences" at any age and from "deprivation".

2) Criticism of Zetzel's views

> **AB** 1963/1965, p. 255
> **(1)** Firstly, do I attribute psychosis mainly to severe traumatic experiences, partly of deprivation in early infancy? […] I have definitely stated that in the aetiology of psychotic illness and particularly of schizophrenia (except in so far as hereditary elements are operative) there has to be noted a failure in the total infant-care process. In one paper I went so far as to state: 'Psychosis is an environmental deficiency disease'. **(2)** Zetzel uses the term 'severe traumatic experiences', and these words imply bad things happening, things that look bad from the observer's point of view. **(3)** 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. **(4)** In other papers I have explored in great detail the kinds of failure that constitute failure of basic provision. 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.

Comments: (1) Winnicott restates his view already expounded in 1948 (see 1948/1958, pp.162) that psychosis (schizophrenia) is an environmental deficiency disease and that failures in the behavior of the mother (i.e., the caretaker) is an essential external traumatic factor in babyhood. **(2)** The origin of psychosis ascribed to Winnicott by Zetzel: severe bad traumatic experiences *from the adult's objective point of view*. **(3)** Winnicott starts his criticism by recalling examples of Winnicottian traumatic factors present in the tortoise dream case, namely, the failures of *basic provision* either in therapy, like his going away to the United States, or in infant care, *from the viewpoint of the immature baby/patient regressed to extreme dependence*. **(4)** In early stages of life, Winnicott argues, traumatic factors need not be severe bad events in the mother-baby relationship, but simply events that are unpredictable and cannot be dealt with by mental mechanisms (because these are not yet available). They do not result in instinct frustration, but in annihilation, the interruption of the continuity of being and of the establishment of the unit self.

3) Relevance of the topic for treating borderline cases and for the theory of schizophrenia

> **AC** 1963/1965, p. 256
> It is valuable to me to have the opportunity to take up this description of my attitude to this subject, 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. Borderline cases are the main exemplars of Winnicott's maturational pathology, as pointed out in Dias, 1994/2011.

4) Prevention of trauma leading to annihilation in early babyhood

> **AD** 1963/1965, p. 256
> **(1)** Mothers who are not themselves ill do in fact avoid this type of failure of care of an infant. **(2)** Under the heading 'Primary Maternal Preoccupation' I have referred to the immense changes that occur in women who are having a baby, and it is my opinion that this phenomenon, whatever name it deserves, is essential for the wellbeing of the infant. It is essential because without it there is no one who is sufficiently identified with the infant to know what the infant needs, so that the basic ration of adaptation is missing. **(3)** It will be understood that I am not just referring to adaptation in terms of the satisfying of id-drives.

Comments: (1) Healthy mothers avoid in their infant care traumatic failures that generate psychotic defenses. **(2)** They do so by developing *primary maternal preoccupation***. (3)** This is an essential remark: a mother or therapist that causes a psychosis-inducing trauma fails not the baby's id-needs (instinctual needs) but its ego needs, those that arise from the tendency to integrate.

8. An overview of Winnicott's general theory of age-related etiological factors, both internal and external

Next, Winnicott recalls his classification in terms of the etiology of the major maturational disturbances that may come up during one's life, a view that is not the subject of the paper and was developed in earlier essays: internal conflicts, privation and deprivation (see 1959-1964/1965).

1) A maturational framework for understanding the etiology of early traumas

> **AE** 1963/1965, p. 257
> **(1)** A basic ration of environmental provision facilitates the very important *maturational developments* of the earliest weeks and months, and **(2)** any failure of early adaptation is a traumatic factor **(3)** interfering with the integrative processes that lead to the establishment in the individual of a self that goes on being, that achieves a psycho-somatic existence, and that develops a capacity for relating to objects.

Comments: (1) Restates the idea that favorable environmental conditions are needed for the healthy maturation of a human baby (see also 1960a/1965, p. 43). In **(2)**, trauma in the early stages is seen as an environmental failure of early adaptation to the baby's need for integration, thus *not* as repression of already integrated instinctual drives. **(3)** Mentions basic

varieties of disturbance – continuance in time of the self, spontaneous gestures produced by the self, personalization (indwelling in the body) and relating to subjective objects – that may affect the main lines of the maturational processes occurring at the time of the first theoretical feed.

2) Internal conflicts in toddlerhood and later

> **AF** 1963/1965, p. 257
> **(1)** It is in psycho-neurotic illness that we find the conflicts that are truly personal to the individual, and relatively free from environmental determinants. **(2)** One needs to be healthy enough at the toddler age to achieve psycho-neurotic illness, let alone health in this area.

Comments: (1) In traditional etiology, neuroses are internal conflicts only indirectly conditioned by environmental failures and the corresponding distortions of the maturational processes before toddlerhood. **(2)** One needs health to become neurotic, and even more health to recover from neurosis. This is not the subject of the chapter. Inherent conflicts are not as deeply traumatic as those that threaten ego-integration, but are nevertheless painful, intolerable and anxiety-arising.[4]

> **Further reading:**
>
> **AG** 1959-1964/1965, p. 136
> **(1)** Let us now look at the internal factors, those which concern us as analysts. Apart from the study of healthy persons, it is perhaps only in *psycho-neurosis* and *reactive depression* that one may get near to the truly internal illness, the illness that belongs to intolerable conflict which is inherent in life and in living as whole persons. **(2)** It might be a definition of relative psychiatric health that in the healthy one can genuinely carry the difficulties that the individual encounters back to the inherent struggle of individual life, the (unconscious) attempt of the ego to manage the id and to use id-impulse in the fullest possible way in relationship with reality. **(3)** It is important for me to make this clear because some may feel that in putting forward a method of classifying which includes a classification of environment I am leaving aside all that psycho- analysis has gained in the study of the individual.

Comments: (1) Etiologically relevant conflicts occur in the stage of concern and, later, in the first triangular (Oedipal) relationships. **(2)** A theoretical point: for neurosis or reactive depression to develop, the individual must be basically healthy. **(3)** By drawing attention to the need to study individuals in different types of pathogenic environments, Winnicott does not lose sight of the results of research on the individual per se, that is, on his internal world.

2) Establishment of the basis of mental health, that is to say, of maturity in early stages

> **AH** 1963/1965, p. 257
> It is in the earlier stages that the basis of the mental health of the individual is being laid down. This involves: (a) maturational processes, which are inherited tendencies, and (b) the environmental conditions that are needed if the maturational processes are to become actual.

[4] On psycho-neurosis, see 1961/1989; on conflicts as etiological factors, see 1959-1964/1965.

Comments: This basic Winnicottian binomial – maturational processes and facilitating environment – is at the core of his theory of health and ill-health.

3) There are the two kinds of basic environmental failures: privation and deprivation

> **AI** 1963/1965, p. 257
> **(1)** In this way, failure of early basic environmental provision disturbs maturational processes, or prevents their contributing to the individual child's emotional growth, and it is this failure of the maturational processes, integration, etc., that constitutes the ill-health that we call psychotic. This failure of the environmental provision (privation) is not usually referred to by the word "deprivation", hence my need to correct the words of Zetzel's reference to my work. **(2)** A complication in the making of this statement is the fact that there is an intermediate position, one in which environmental provision is at first good, and then fails. It succeeds in that it allows of ego-organization of considerable degree, and then it fails at a stage before the individual has become able to establish an internal environment – that is, to become independent. This is what is usually called a: "deprivation", and it does not lead to psychosis; it leads to a development in the individual of an "antisocial tendency", which may in turn force the child into having a character disorder and becoming a delinquent and a recidivist.

Comments: (1) Statement on the etiology of psychosis, which, unlike psycho-neurosis or reactive depression, does not arise from intolerable inner conflict that takes place within a whole person and pertains to the management of the instincts, but is related to privation in early life that threatens with annihilation, as exemplified by maternal failures in the case of the tortoise dream. The treatment, as seen above, requires management followed by maturational analysis. **(2)** *Deprivation* is the sudden loss, at any stage after the establishment of I AM, of a previously good-enough external environment due to an external factor, which may hamper maturation towards independence. This is the etiology and diagnosis of antisocial tendency exemplified by the case of the 2-year-old boy. In treatment, the patient needs management by spoiling so that he might acquire independence, first by becoming a nuisance, later by stealing.

9. Implications of Winnicott's etiology for the treatment of psychotic borderline patients

1) Self-cure and snack-bar psychotherapy

> **AJ** 1963/1965, p. 258
> **(1)** One is that it is in the psychoses – not in the psycho-neuroses – that we must expect to find examples of self-cure. **(2)** Some environmental happening, perhaps a friendship, may provide a correction of a failure of basic provision, and may unhitch the catch that prevented maturation in some respect or other. **(3)** In any case, it is sometimes the very ill child in child psychiatry who can be enabled to start growing by snack-bar psychotherapy, whereas in the treatment of psycho-neurosis one always wants to be able to provide a psycho-analytic treatment.

Comments: (1) In the case of psychosis, self-cure, a friendly environment and "snack-bar" psychotherapy may be helpful to unblock the forward movement of maturation. Not so in psychoneurosis. **(2)** This kind of help is effective because it corrects the original failure to meet

ego-needs and does not prevent the fulfilment of primitive id-needs. **(3)** Snack-bar psychotherapy can work well in child psychiatry.

2) Good psychoanalytic technique does not aim to provide corrective experiences

> **AK** 1963/1965, p. 256
> Certainly no analyst *sets out to provide* a corrective experience in the transference, because this is a contradiction in terms; the transference in all its details comes through the patient's unconscious psycho-analytic process, and depends for its development on the interpreting that is always relative to material presented to the analyst.

Comments: No provision of corrective experiences – this is a basic rule accepted by Winnicott for both psycho-neurotic transference (transference of repressed unconscious material) and psychotic transference (establishment of an ego or personal dependence relationship).

3) Good, ordinary psychoanalytic technique may be a corrective experience

> **AL** 1963/1965, p. 258
> Of course, the practising of a good psycho-analytic technique *may* in itself be a corrective experience, and for instance in analysis a patient may for the first time get full attention from another person, limited though it be to the reliably established fifty-minute session; or may for the first time be in contact with someone who is capable of being objective. And so on.

Comments: The kind of technique specified in this excerpt may work with some borderline cases requiring regression to dependence. For many of them, full attention in a setting defined by rules and temporally limited may provide a corrective experience, because these patients may benefit from an attentive and objective therapist.

4) Why the provision of good-enough holding may not be enough for psychotic patients

> **AM** 1963/1965, p. 258
> **(1)** But even so, the corrective provision is never enough. What is it that may be enough for some of our patients to get well? **(2)** In the end the patient uses the analyst's failures, often quite small ones, perhaps manoeuvred by the patient, or the patient produces delusional transference elements (Little, 1958) and we have to put up with being in a limited context misunderstood. **(3)** The operative factor is that the patient now hates the analyst for the failure that originally came as an environmental factor, outside the infant's area of omnipotent control, but that is now staged in the transference.

Comments: (1) However, even the provision of good care in the sense explained above will not be enough for the patient thus diagnosed to recover from the original breakdown. Why not? **(2)** To recover from a prior breakdown, from the corresponding unthinkable anxieties and from his or her own defenses against these anxieties, and to continue the maturational process, the borderline patient needs, to begin with, a therapeutic environment – professional, familial or otherwise – that offers *basic holding*, a *good enough lap*, which the mother failed to provide and which is something very different from full attention or a sense of objectivity. The recovery process, which will begin after the patient has received this kind of basic provision – when, at last, what needed to have happened (but did not happen in the past) happens – will only continue

if the patient can get in touch with his unthinkable anxieties and, thus, shape, with its breakdown. For this to occur, the therapist must provide a new type of facilitation: to fail in a limited way, in small doses, so that the patient's original total madness might now be relived as a local madness, on the brink of being integrated, leaving the past behind. In other words, for such a patient, a therapist will only be good enough if he makes mistakes that patient himself led him to make, but that are not as serious as those made by the un-adapted mother shortly after the patient's birth (and were impossible to encompass due to the child's immaturity), but are similar enough to those of a good enough mother in the process of *de-adapting* her child. At this stage, the patient has already begun to develop his own mental capacities and is already able to deal emotionally and behaviorally with a mother who is no longer under his omnipotent control. For the treatment to yield good results, the patient will need to have made an analogous maturational achievement, along the lines of maturation of the self towards I AM. The woman who dreamt of a tortoise did not achieve this, and so her treatment had to, first of all, establish and strengthen her own self. In most cases, however, the therapeutic work is carried out with a later version of the breakdown, when the patient, who is no longer a baby, has already attained a certain amount of personal autonomy (1959-1964/1965, p. 139). **(3)** This is the maturational condition to activate the main operating factor of healing: the patient's anger and hatred towards the admittedly flawed therapist, who he can now control emotionally and mentally. In this way, what was lost in the original breakdown, namely, the experience of omnipotent control of the phenomena arising in the mother's lap, can finally be recovered, at least in a limited way. Thus, the therapeutic external factor is brought under emotional control and can be managed mentally by projection and introjection mechanisms, capabilities that can now be used profitably both in the therapeutic situation and in life. It is this experience that the patient needs in order to continue to establish himself as a stable unit self and to be able to feel, understand and tolerate anger and hatred[5].

5) Curing by the therapist's failure

> **AN** 1963/1965, p. 258
> **(1)** So in the end we succeed by failing – failing the patient's way. This is a long distance from the simple theory of cure by corrective experience. **(2)** In this way, regression can be in the service of the ego if it is met by the analyst, and turned into a new dependence in which the patient brings the bad external factor into the area of his or her omnipotent control, **(3)** and the area managed by projection and introjection mechanisms.

[5] The essential relation between the patient's needs for regression and the therapist failing in the manner needed by the patient, which is a central point of Winnicott's "Fear of Breakdown", was first studied in Brazil by Elsa O. Dias in her 1994/2011 paper, which became a cornerstone of the teaching and research carried out at the IBPW. See also Dias, 2022.

Comments: (1) The analyst's failures, when they correspond to the patient's needs, can contribute to recovery. They do not, however, because of this, provide a corrective experience. **(2)** Although condemned to suffer extreme pain from the breakdown caused by severe environmental failures of the original bad external factor (i.e., of the mother), which were beyond ego-control and were accompanied by unthinkable anxieties, the patient can be saved from such a fate by moderate – or even, objectively speaking, very small – environmental failures committed later by another external factor, the therapist. These failures are, indeed, failures, because they expose the patient to anxieties; however, unlike the original devastating anxieties, the new ones – especially when experienced in a trusting therapeutic relationship – can be tolerated by the patient and submitted to his control, being neither overwhelming nor unthinkable. The patient emerges strengthened from this experience of omnipotence, even if limited. This *use of the therapist's failure*[6] means that the patient is entering a *new* type of dependent relationship, that he no longer depends on mother providing the initial good enough type of holding, and that he henceforth will need someone who, despite being the object of his or her anger and attacks, will continue to facilitate his process of maturation – much like what the good enough mother does in the period of relative dependence, as stated above. In Winnicott's jargon, the patient needs a therapist who "survives". Having placed the therapist's failures in his area of omnipotence – and mental development is quite helpful in this regard – the patient can now begin the journey towards independence. **(3)** In particular, the mental mechanisms of projection and introjection help emotionally to control the moderately bad external factor, namely, the therapist who makes mistakes – which, paradoxically, help to heal.

10. Applying these ideas to the case of the woman who dreamt of a tortoise

> **AO** 1963/1965, pp. 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.

Comments: (1) The good_enough therapist must fail in the manner required by the patient and at the right time, i.e., when the patient is ready to deal with this failure, that is to say, to integrate it in his life which is going on. **(2)** Winnicott fears having failed too early or

[6] At this point, Winnicott's theory of the patient's use of therapist's failure is closely connected to his general theory of the use of an object (1968/1971).

too grievously the woman who dreamt of a tortoise, thus adding a new annihilating trauma to the earlier one derived from her mother's failures.

11. Structural features identified

Summing up, the analysis presented here identified the following structural features of Chapter 23: 1) the intended audience; 2) the main objective: the study of dependence in treatment and in early family life (babyhood and childhood); 3) a case exemplifying professional failure in adequately tending to the dependence needs of patients who suffered in babyhood from privation (psychotics), which is the main kind of early trauma; 4) reflections on the paradigm shift from traditional analysis to Winnicott's total response procedures in the treatment of such patients; 5) a case illustrating an environmental failure leading to deprivation, which is the second main kind of early traumas resulting in antisocial or nuisance-producing tendency, and the success of this same nonprofessional environment in providing the care needed for recovery; 6) reflections on child psychiatry and its relations to psychoanalysis; 7) a discussion of other views about the nature of early traumas; 8) an overview of Winnicott's general etiology stated in previous writings; 9) implications of these views for the treatment of psychotic borderline patients in particular; and 10) a look back on the tortoise case.

12. Place of Chapter 23 in Winnicott's work

The paper from 1962 restates also some central elements of the theoretical structure Winnicottian paradigm as a whole.

1) The binomial: maturational processes and facilitating environment.

2) Several theses on maturational theory and maturational pathology.

3) Settings and treatment procedures to meet regression to dependence, as well as considerations on what happens in the psychoanalytic setting. Winnicott also brings to discussion clinical phenomena, both pathological and healthy, observed in other kinds of treatment settings, such as the family, mental hospitals and child psychiatry consultations.

4) Paradigmatic exemplars of two main categories of Winnicott's revolutionary classification of maturational disturbances: psychosis and antisocial tendency.

This last topic is very clearly restated in the Introduction (1965) to *The Maturational Processes and the Facilitating Environment.*

> **AP** 1965, p. 9
> The beginning of ego emergence entails at first an almost absolute dependence on the supportive ego of the mother-figure and on her carefully graduated failure of adaptation. This is part of

> what I have called 'good enough mothering'; in this way the environment takes its place among the other essential features of dependence […].
> One aspect of the disturbance of ego emergence produced by environmental failure is the dissociation that is seen in the 'borderline case' in terms of the true and the false selves. […]
> Following up the idea of absolute dependence in earliest infancy I put forward a new way of looking at classification.
> The origin of the antisocial tendency is discussed. It is postulated that the antisocial tendency is a reaction to *deprivation*, not a result of *privation*; in this way the antisocial tendency belongs to the stage of relative (not absolute) dependence. […]
> As a corollary to all this, the more psychotic disorders are seen to be closely related to environmental factors, whereas psycho-neurosis is more essentially natural, a result of personal conflict, and not to be avoided by satisfactory nurture.

We can see Chapter 23 as a more thorough development of these same topics and, thus, as the key piece of the book. Indeed, it provides a restatement of Winnicott's theory of dependence on the family setting during infancy and childhood, on the one hand, and in therapeutic settings, on the other, the mainspring of his revolutionary change in psychoanalytic theory and clinical practice.

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