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Winnicott's Clinical Cases: Their Structure and Uses

Z. Loparic
IBPW/IWA

Abstract: This study aims to analyze the structure of Winnicott's clinical cases – i.e., the series of guiding ideas he uses to prepare his accounts – and to explain their theoretical and therapeutic usage.

1. Guiding ideas for the study of Winnicott's clinical cases

Winnicott's works include many clinical cases, of different types, rounded off with numerous vignettes that greatly enrich his texts. Case materials arouse the immediate interest of readers, both professional and amateur, but might there have been some kind of script by which these accounts were prepared? In other words, are Winnicott's clinical cases perhaps structured according to a set of guiding ideas borrowed from his theory? Another question also arises: why so many and such detailed cases in Winnicott? How did he expect them to be used?

Before attempting an answer, we should bear in mind that clinical cases are an integral part of professional literature in psychoanalysis and other fields of study and treatment of mental health. Freud, for instance, although, also availing himself of figures from literature, mythology and religious narratives, also took great care to provide detailed clinical illustrations for various core aspects of his sexual Oedipal interpretation of human psychopathology. Unlike Freud, Jung illustrated his clinical ideas almost exclusively through literature and mythology. In Klein, clinical materials regain a central place; in Fairbairn, they are scarce; in Bion, they are no more than vignettes; in Lacan, except for the case of Aimée, literature and religion take up almost the entire scene; whereas in Kohut, clinical practice withers amidst abstractions.

To these questions, I will seek answers aligned with the interpretation of Winnicott's work I have been developing with Elsa Oliveira Dias since 1995. In this interpretation, Winnicott wrought a revolutionary change in the theory and in the treatment of nonphysical health disorders, resulting in a *new paradigm* for their conceptualization and resolution.[1] Going against the grain of traditional psychoanalysis, he no longer conceived these problems as

[1] The first formulation of this thesis is found in Loparic, 1996. For a more complete formulation, see Loparic, 2002 and 2023b.

mental disorders, i.e., as dysfunctions of the *psychic apparatus* or gaps in the temporal order of *conscious states* (e.g., affects, representations) created by a censorship mechanism that expels from consciousness some of these states and creates a *repressed unconscious* that is both *pathogenetic* and generator of symptoms, comprised of events that happened but should not have. These lacunae can be filled, restoring health, by recollecting these out-of-control unconscious states (however encrypted they may be) during transference, accompanied by the analyst's deciphering, disciplinary and instructive interpretations. Winnicott does not see the problems he studies and treats as mental alterations, but as *maturational* disorders, i.e., as deviations or even blockages of *instances of human nature over time*, derived not from events that happened yet should not have, but from events that did not happen in the process of *emotional and personal maturation* yet needed to have happened, i.e., from an *unconscious that did not come about* yet is pathogenic and generator of defensive disorders. Maturational disorders can be treated by enabling the patients themselves to resume their lines of maturation (through the analyst's management and, eventually, interpretations) so that what needs to happen can happen.[2] To acquaint readers with his theoretical ideas and his radically new procedures, Winnicott systematically resorted to well-articulated and detailed illustrative examples. I hope to help readers make good use of this material.

Thus, my purpose here is not historical. I will draw attention to the fact that Winnicott clinically exemplified his theory of health as age-adjusted maturation, his pathology as a theory of immaturity, his clinical practice as facilitating the resumption of maturation. And it should be emphasized that Winnicott did so in order to teach his paradigm, guide research and abet treatment (see details below). It should also be noted that Winnicott's clinical cases are the cornerstone of the Graduate-Level Course on Winnicottian Psychoanalysis offered by the Brazilian Institute of Winnicottian Psychoanalysis (IBPW), comprising one-third of the students' instruction.

2. What Winnicott's cases are not

The study of Winnicott's clinical cases calls for a sober reader. Indeed, when collated with the accounts conceived and produced by many other psychoanalysts, one can easily discern what Winnicott's cases are not. They are not:

1) Mere narratives of episodes in the patients' life or treatment

2) Tales from his 60,000-plus sessions

[2] On the lines along which the different stages unfold over the course of maturation, see Loparic, 2023a.

3) *Mises-en-scène* that aim to involve readers emotionally or allure them intellectually

4) Fictions or forged narratives

5) Pieces for amusement or entertainment

6) Melodramas at the patients' expense that leave the reader heartbroken

7) Analyses of literary works, plays, films, soap operas or series

8) Analyses of myths or religious fantasizing

9) Inducements to the reader's voyeurism (delighting oneself by observing therapy sessions through a keyhole)

10) Occasions for showing off cleverness

11) Marketing postings

12) Essays for theoretical, clinical, religious or ideological enticement or grooming.

This list of non-Winnicottian clinical narratives could be much longer and detailed, for non-Winnicottian clinical cases can be found everywhere in literature. I will give two examples. When writing a clinical report, J.-D. Nasio resembles a stage director (*metteur en scène*) that seeks to create for his audience the enveloping tension and suspense of a theatrical drama (Nasio, 2000, p. 22). For Ogden, in turn, the patient of a clinical case is not, nor should be, a real person on the couch, but an imaginary character, a literary fiction, a verbal invention. The analyst writing about him or her can, and should, invent almost every line of dialogue, for the account does not illustrate experiences with a patient in the consulting room; it is merely a metaphor for them (Ogden, 2022, p. 164).

3. What Winnicott's clinical cases are

Back to Winnicott, his cases are scientific accounts that exemplify his therapeutic activity in various fields of health care, i.e., of solving problems of personal maturation. They are not, therefore, disorders of a physical nature (although they may involve a somatic side) and should be treated according to procedures aligned with Winnicott's *theory of human nature* (or *maturational anthropology*, different from both cultural and physiological anthropology), which at its core comprises a theory of healthy maturation, maturational pathology and maturational clinic. They are cases of applied science, which uses the science of humankind

conceived and ushered in by Winnicott,[3] aimed at professionals, students and readers interested in the fields of pediatrics, child psychiatry, psychoanalysis and social work, among others.

Within the framework of the philosophy of science, Winnicott's accounts can be seen as Kuhnian exemplars. According to Kuhn (1962-1970, pp. 35-42), empirical science is a problem-solving activity in a given field and deals with certain types of data and unknowns. This activity is guided by paradigms, i.e., disciplinary and exemplary matrices – exemplary solutions to exemplary problems in the field under study.[4]

4. The structure of Winnicottian clinical cases

A comparative study shows that the most elaborate Winnicottian exemplars, even if lacking the same explicit conceptual articulation or the same wealth of data, have a *structure* composed of the following elements:

1) Place of the case account in Winnicott's work
2) Clinically relevant facts of the case. Patient's overall history
3) The person of the patient
4) Maternal, familial and social environments
5) Main figures of the environment
6) Symptoms: data on the disease
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 stages
15) Therapeutic results
16) Case summary
17) Theoretical results

[3] Winnicott's theory of human nature can be profitably compared with Kant's pragmatic anthropology, which is neither a philosophical discipline nor a natural science such as empirical psychology, and which studies through observation the inherited human capacities, their development and uses in life, particularly in the creation of moral character and the attainment of personal, social and humanity-wide ends.

[4] For a study of Winnicott's clinical cases as Kuhnian exemplars, see Loparic, 2009 and 2011.

18) Follow-up.

In keeping with this structure, each case can be situated within the whole of Winnicott's work (items 1, 17), illustrating with clinical data the main aspects of instances of human nature over time: personal maturation (items 2, 5), environmental conditions of maturation (items 3, 4), pathology of maturation (maturational blockages and disorders, items 6-9) and the conditions and path to reestablish the maturational process (items 10-16, 18). Seen in its entirety, a case with this type of material and framework is a scientific exposition of one or several scenes of human suffering ("spokes of the wheel of life"[5]), as every human life, from conception and birth onward, must go through successive new phases of achievement, crisis and recovery.

5. Details of the structure of the cases

What follows are brief notes on the 18 items of the case structure that one should take into account when reading and analyzing the structure of one of them. The notes rest on material found in Winnicott's accounts or that can be reconstructed from relevant parts of his body of work. Some items that are more central or have greater conceptual complexity will be emphasized. In IBPW's Graduate-Level Course on Winnicottian Psychoanalysis, the same items are considered in the preparation of case reports for supervision and end-of-course assignments.

1) Place of the case account in Winnicott's work

Winnicott's work comprises numerous types of texts: theoretical expositions on elements of his paradigm, accounts of clinical cases, outreach articles for specific audiences, texts applicable to non-clinical areas, among others. In specifying the place of a case account in Winnicott's work, the following points should be considered:

a) Chronology of its publication

b) Target audience

c) Relevance of the original theoretical and clinical research findings

d) Relevance of the case as an example of Winnicott's professional activities in the areas of pediatrics, child psychiatry, psychoanalysis and social work, based on previous findings, and

[5] For the concept of spokes of Winnicott's wheel of life and a representative infographic, see Loparic, 2023a.

of his role as a parental advisor, educator and promoter of his ideas on human nature vis-à-vis physical nature.

e) Illustrative aspects of Winnicott's disciplinary matrix: paradigmatic problems, theories and guiding ideas, theoretical assumptions (universals of human nature, spontaneity, primary creativity, tendency towards integration and the maturational process, and their instances over time), research and treatment procedures, values, and instrumental and institutional commitments.

The cases of the girl who dreamt of a tortoise, Piggle, Patrick and George in *Therapeutic Consultations* are among those that illustrate these points very well (1977, 1971).

2) Clinically relevant facts of the case. Patient's overall history

This item is not a matter of seeking biographical data, but of specifying actual facts of the patient's life relevant for understanding how external factors influenced both the healthy development and the patient's disease; for evaluating potential consequences of internal conflicts in human life upon which to base the diagnosis and etiology of the case; and for referral of treatment. Winnicott says:

> It was as a practising paediatrician that I found the therapeutic value of history-taking, and discovered the fact that this provides the best opportunity for therapeutics, provided that the history-taking is not done for the purpose of gathering facts. Psycho-analysis for me is a vast extension of history-taking, with therapeutics as a by-product. (1961b/1965, 198-199)

Examples of clinically relevant facts: 1) early traumas in the stages of almost absolute dependence resulting from maternal failures leading to the breakdown of the continuity of being and of the constitution of the unit self, and 2) actual sexual trauma caused by social or internal censorship. Regarding the latter, Winnicott defends a return to Freud's initial position:

> […] 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. (1962a/1965, p. 251)

3) The person of the patient

The focus here is on innate and acquired capacities, psychosomatic aspects, personality structure, talents, tastes, social relationships and character traits. In Winnicott, the patient is not

the brain or the psychic apparatus, but a whole person – the instance in maturational time of the inherited potential that characterizes human nature.

4) Maternal, familial and social environments

The most relevant points here are the environment-mother and the familial, social and cultural environments, in their dual role as facilitators of the patient's healthy development, or as impediments that give rise to maturational pathologies (the Winnicottian environmental etiology; see below). The initial traumatic factors are the environmental ones, and they remain relevant for analyzing the influence of internal factors (see item 8, "Etiology").

5) Main figures of the environment

In the initial environments, the main figures are the mother, father and siblings, as well as other close relatives; in later and broader environment, the teachers, friends, therapeutic agents, social and political figures, and exponents of cultural life.

6) Symptoms: data on the disease

Symptoms are not mere facts, but communications that need to be understood as calls for help with maturational needs that were not met in a timely manner:

> The psychiatrist is therefore not a symptom-curer; he recognizes the symptom as an SOS call that justifies a full investigation of the history of the child's emotional development, relative to the environment and to the culture. Treatment is directed towards relieving the child of the need to send out the SOS (1953/1958, p. 102)

Symptoms, therefore, have meaning, and this meaning must be spelled out in terms of Winnicottian classifications of maturational symptoms that are communications of maturational problems relating to:

Distortions, deviations or blockages of the maturation process by external factors (privation, deprivation).

Pathological results of internal conflicts related to the management of instincts. In many cases, there is a varied, extensive and not always manifest symptomatology related to maturational problems driven by external factors.

Example 1. Psychosis as a defense organization and as a symptom of breakdown.

> It is my intention to show here that what we see clinically is always a defence organisation, even in the autism of childhood schizophrenia. The underlying agony is unthinkable.
>
> It is wrong to think of psychotic illness as a breakdown, it is a defence organisation relative to a primitive agony […] (1963a/1989, p. 90)

Example 2: Antisocial tendency as a defense organization and as a symptom.

> The antisocial tendency represents the S.O.S. or *cri de coeur* of the child who has been at some stage or other deprived, deprived of the environmental provision which was appropriate at the age at which it failed. The deprivation altered the child's life; it caused intolerable distress, and the child is right in crying out for recognition of the fact that "things were all right, and then they weren't all right," and this was an external factor outside the child's control. (1961a/1989, p. 65)

Example 3. Neurosis as a defense organization and as a symptom.

> We must say clearly that the healthy toddler has every possible kind of psycho-neurotic symptom […].
>
> However, the child finds certain aspects of the anxieties intolerable, and so begins to set up defences. These defences organise and we then speak of psycho-neurosis. (1961a/1989, p. 67 e 68)

7) Diagnosis

Diagnosis deserves special attention, being the foundation of treatment: "The essential thing is that I do base my work on diagnosis. I continue to make a diagnosis of the individual and a social diagnosis as I go along, and I do definitely work according to diagnosis" (1962b/1965, p. 169).

The guiding idea that governs all of Winnicott's work implies: 1) studying human nature along the lines with a single and central theme, namely, human existence in the world as a process of maturation that begins at conception and goes on until death, and 2) bringing together the findings of every possible approach to existence in a unified formulation, namely, the theory of healthy maturation through growth, development and integration (see 1988, p. 7-8 and 33-34; Dias, 2017). Accordingly, the Winnicottian diagnosis is *maturational*: it ponders over samples of immaturity in human nature and is based on universal aspects of human nature

(one's inherited potential) in terms of the theory of healthy maturation and of maturational pathology. When carried out in this context, the study of human existence seeks: firstly, to elaborate, by following the successive stages of life, the common structure of the total stories of human individuals (1971, p. 6); and, secondly, to specify the temporal place both of healthy developments that occur along the various lines of maturation,[6] and of distorted ones, resulting from interruptions of this process through the impingement of external or internal factors (internal conflicts) and the defensive reactions against these factors (anxieties of various sorts and severity and their corresponding defenses).

This allows Winnicott to conceive and classify non-physical pathologies as distorted *revelations* of human nature that emerge over the course of maturation. These revelations appear as human stories created defensively as patterns of a life still deemed possible, as escapes to false refuges, as false narratives, as false solutions that denote the distorted fate of one's inherited potential through dependence on increasingly larger and more sophisticated environments (which are never good enough) and, like SOS signals, are actually calls for help in the face of the dangers that threaten the maturational process. These defense organizations are somewhat rigid and, therefore, diagnoses can be made based on them (1965/1989, p. 128).

In this theoretical context, case accounts can be written and read as duly structured collections of descriptions of episodes of a twisted or stuck human life: "A psycho-analytic case description is a series of case histories, a presentation of different versions of the same case, the versions being arranged in layers
each of which represents a stage of revelation" (1959-1964/1965, p. 132).

As such, it is easy to see why Winnicott flatly rejects the psychiatric idea that illnesses are something *in* the individual, yet are not the individual's ways of being because they are not part of his or her personal history. This idea, as Winnicott sees it, emerged from studies that detach episodes of maturational disturbances from the fabric of the patients' lives, and isolates them through various types of objectifying paradigms. This is often carried out to such a degree that those episodes no longer seem to be aspects of one's personal existence in a shared world, and resemble more cyst-like entities or anomalous growths that bother, disrupt and, ultimately, command the individual's life. And, of course, they then have to be extirpated, along with their causes, by invasive occupational or behavioral therapies, or by neurobehaviorism,[7] for example,

[6] Line 1: personal integration; line 2: somatic development and psychosomatic integration; line 3: mental development; line 4: socialization; line 5: cultural life.

[7] Regarding behaviorism, Winnicott says: "But human nature is not like physiology and anatomy, although based on it, and doctors are again, by self-selection, selection, and training, unfitted to do the

pushing people away from themselves and hindering the maturational processes, or through medication (chemistry), physical procedures (electroshocks) or even surgery (lobotomy, reassignment surgery). The Winnicottian therapist views things differently:

> The analyst gets a view of mental disorder which is very different from that of the psychiatrist who makes a very careful examination of a patient at a certain moment in the history of the case, as for instance when there has been a breakdown or when hospitalization has occurred. (1959-1964/1965, p. 132)

Thus, the breakdown mentioned above, whether or not followed by hospitalization, cannot be studied or treated exclusively as an adult phenomenon isolated from one's past life. Rather, as Winnicott expounds in "The Fear of Breakdown," it must be referred to the initial stages of this immature adult baby, almost absolutely dependent, as a disruptive alteration of his or her maturational process.[8]

It is important to bear in mind that, in many cases, the final diagnosis is only reached during the therapeutic process. This does not mean, however, as we saw in the quotation above, that therapy can take place without a diagnostic hypothesis, even if provisional.

> [1] It is possible to trace a disorder in a patient from childhood through adolescence and through early and late adult life, and to see the way in which there has been a transmutation all along the line from one type of disorder to another. [2] In this way it is impossible for the analyst to retain any idea he may have had from his formal psychiatric training that there are definite psychiatric diseases. In fact it becomes evident to the analyst in the course of his analytic work that in so far as psychiatry concerns diagnosis it is making a tremendous attempt to do the impossible, since a patient's diagnosis not only becomes clearer as analysis proceeds but also the diagnosis alters. [3] 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. (1959-1964/1965, p. 132)

Comments. According to [1], the patient may, in life and during treatment, use different defense organizations, revealing different types of maturational disorders – e.g., defenses against later, easier to control disorders can be used to cover up earlier, more severe disorders. [2] Therefore, it is impossible to make diagnoses based on defined noological categories. [3] As a result, the same person may display neurotic and psychotic symptoms alternately. Likewise, homosexual symptoms (FM's case, 1966/1989, 1959b/1989 and 1963b/1989), or

social worker's job of acknowledging and containing and believing in human conflict and suffering, which means tolerating symptoms that give evidence of deep distress" (1969/1989, p. 559).

[8] On Winnicott's theory of madness as maturational breakdown, a key concept in his theory of psychosis, see (1963a/1989 and 1965/1989).

psychosomatic (case of anorexia nervosa, 1964/1989, p. 107-108) or antisocial ones (George's case, 1971, pp. 380-396) can be used defensively when core psychotic anxieties threaten to break down existing defenses (1971, p. 87-88).

8) Etiology

In parallel with two main types of maturational diagnosis that take into account environmental disturbances, internal disturbances and the corresponding reactions, Winnicott considers two basic types of etiology: external factors (privation and deprivation) and internal instinct-driven conflicts. Both are maturational and elaborated by history-taking of the case in question.

> The aetiology of psychiatric disorder now demanded of the clinician an interest in history-taking. In this way the psycho-analysts became pioneers in psychiatric history-taking, and it is they who have recognized that the most important part of history-taking derives from the material arrived at in the course of psycho-therapy. (1959-1964/1965, p. 124-25)

9) Prognosis

Prognosis is based on diagnosis and on the results of the therapeutic process achieved in each case.

10) Therapeutic setting or settings

Winnicott carefully specifies the settings used in treatment, which may be individual or social (institutional), natural or professional. "Psychoanalysis is not just a matter of interpreting the repressed unconscious; it is rather the provision of a professional setting for trust, in which such work may take place" (1970a/1986, p. 114-115).

In the case of Kathleen (1955/1958, ch. 10), the only relevant setting is the family environment (see item 11 below). In Piggle's case, there are three settings: Winnicott's office, the family that became a mental hospital, and the train that takes Piggle and her father, another therapist, from one setting to the other (1977).

11) Therapist or therapists

It is important to consider the number of therapeutic agents directly or indirectly involved in treatment: individuals, acting in natural settings (mothers, fathers, friends, among others) or institutional ones (professional psychoanalysts, social workers), or even

environments, which in various ways influence the patients therapeutically. This, for example, is what Winnicott says about Kathleen's therapeutic caregivers:

> I found that [Kathleen's] mother, who was not an educated woman and not actually very intelligent, but an excellent manager of her home, was interested to know why she and the family had turned themselves into such a curious and abnormal state. She did in fact keep up the mental hospital atmosphere until the child was ready for the home gradually to return to normal. The gradual recovery of the home followed as the child lost her paranoid defence organization. I had the co-operation of the local authority even when I asked that no one should visit the home and for a whole year I took full responsibility, thus simplifying the mother's task. (1955/1958, p. 119)

12) Therapeutic relationship

a) On the patient's side

For the patient, the therapeutic relationship involves, among other things, establishing communication, accepting one's dependence on the therapist, issues of trust, and aspects of neurotic transference and of psychotic and delusional transference.

b) On the therapist's side

Among several traits that make for a good therapist, Winnicott often emphasizes the following: personality structure, ability to communicate and cross-identify, aptitude to put oneself in the required position and perform the necessary roles, responsibility towards the patient, proper attitudes (reliability) and honesty (capacity to tell truths that need to be told and to recognize failure).

13) Treatment procedures

Essentially, as we have seen, Winnicott relies on history-taking of the patient's life and environments, and on different modes of interpretation and management, the procedures of which are often combined during the process. This is new:

> If our aim continues to be to verbalize the nascent conscious in terms of the transference, then we are practising analysis; if not, then we are analysts practising something else that we deem to be appropriate to the occasion. And why not? (1962b/1965, p. 169-70)

In a late text, Winnicott evaluates the procedures found in shelters for poor children:

> I would sometimes get David [Wills, director of the shelter for poor children in Bicester, England] and some of his staff to listen while I told the story of the interview, in which I made smashing interpretations based on deep insight, relative to material breathlessly

> presented by boys who were longing to get personal help. But I could feel my little bits of sowing fall on stony ground.
>
> Rather quickly I learned that the therapy was being done in the institution, by the walls and the roof; by the glass conservatory which provided a target for bricks, by the absurdly large baths for which an enormous amount of precious wartime coal had to be used up if the water was to reach up to the navel of the swimmers.
>
> The therapy was being done by the cook, by the regularity of the arrival of food on the table, by the warm enough and perhaps warmly coloured bedspreads, by the efforts of David to maintain order in spite of shortage of staff and a constant sense of the futility of it all, because the word success belonged somewhere else, and not to the task asked of Bicester Poor Law Institution. (1970b/1984, p. 221)

14) Treatment process: its dynamics and stages

a) Dynamics of treatment

This item bears on Winnicott's information on the emotional relationships established between those involved in treatment and on developments in the lines of maturation, e.g., time-space integration. Reversals in maturation and varying degrees of profound regressions, both of instinctuality and personality, are other important aspects of the dynamics of treatment.

b) Stages of treatment

These stages, taken sequentially, are episodes that reveal whether the treatment abets or hinders the resumption of one or other line of maturation, or even reverses it. One should bear in mind that reversal by regression to dependence, under favorable conditions, can be the onset of healing. These episodes may or may not correspond to the stages of maturation, and may or may not parallel the stages of a healthy maturational process (See 1977, p. 2).

15) Therapeutic results

Winnicott's case accounts often provide data on the disappearance of symptoms and, more significantly, on the patient's recovery along the main lines of maturation mentioned above. The key aspect is the patients' ability to lead, on their own, a life worth living.

> It is very satisfactory to watch the patient's growing ability to gather all things into the area of personal omnipotence, even including the genuine traumata.
>
> Ego-strength results in a clinical change in the direction of a loosening up of the defences which become more economically employed and deployed, with the result that the individual feels no longer trapped in an illness, but feels free, even if not free from symptoms. In short, we see growth and emotional development that had become held up in the original situation [before treatment]. (1962b/1965, p. 168)

16) Case summary

Not infrequently, Winnicott summarizes a case by recapping what he had said about the stages of the disease and its treatment. See, for example, Mark's case (1971, p. 270-295). The same can be achieved by the patient in a dream, for example (see Piggle's final dream with everyone – her family and Winnicott –together in a swimming pool, 1977).

17) Theoretical results

Most cases illustrate ideas already formed. However, a significant number also present clinical and theoretical findings, which should be explained and situated in the overall structure of Winnicott's work. The case of the girl who dreamt of a tortoise, for example, illustrates the theoretical and clinical limits of traditional psychoanalysis:

> 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. (1962a/1965, p. 252)

18) Follow-up

These observations provide information on controls of treatment results after its completion.

6. On the uses of the cases

According to Kuhn (1969/1970, p. 187-191), exemplary cases are used as:

1) Illustrations of disciplinary matrices, i.e., guiding theories, and of procedures

2) Teaching aids

3) Models for further research

4) References for other applications (in engineering, medicine, etc.).

One can easily see that Winnicott's clinical cases, as characterized above, can be used for the same purposes as Kuhnian exemplars.

1) Winnicott's cases as illustrations

The case of the girl who dreamt of a tortoise illustrates the relationship of dependence in early life and during treatment by modified analysis and management. Both procedures are

revolutionary novelties of the Winnicottian paradigm. See the case of Patrick for problems addressed by Winnicott's child psychiatry procedures.

2) In teaching

Clinical cases can be valuable material to teach Winnicott's theory of healthy maturation and maturational pathology, as in IBPW's Graduate-Level Course on Winnicottian Psychoanalysis. They are also very useful as educational aids in other areas, such as social work, education and child and adult psychiatry. furthermore, their structure can be used, by students, as a frame of reference to prepare case reports and, by supervisors, to evaluate their students' reports.

3) In research

Cases serve several research purposes: they are useful as exemplars of the application of the scientific method, as pieces of evidence, and as a foundation to build and rebuild theories, to formulate and reformulate procedures, and to decide between theories.

4) In treatment

Winnicott's cases provide exemplary references for therapists to solve clinical problems through applications of his theory of healthy maturation and maturational pathology. They are a basic tool of Winnicottian clinical practice conceived as an applied science of his theory of human nature and its manifested instances over the course of maturation.

7. Final remarks

It is easy to see from the discussion above that Winnicott's accounts on clinical cases are key pieces to access the experiential basis of the various dimensions of his theory of human nature, of their successful or distorted unfolding in time, and of how they can help humans in either case. In other words, they are privileged gateways to study the revolution wrought by Winnicott in psychoanalysis and other areas of healthcare.[9]

[9] In the texts that are being prepared, I will use these items to develop *structural analyses* of several of Winnicott's cases, especially those of the girl who dreamt of a tortoise and of Patrick. I hope to show that these two cases exemplify all 18 items of the framework described here and can be seen as particularly instructive paradigmatic exemplars of the radical novelty and richness of Winnicott's clinical practice – the former in the area of early maturational disorders (psychoses) treated through his modified; the latter in the field of childhood disorders managed by his child psychiatry.

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