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Basics Concepts of Winnicott´s Theory of Schizophrenia

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Introduction

This paper presents a structural analysis of Chapter 29, "The Concept of Clinical Regression Compared with That of Defence Organisation", from *Psychoanalytic Explorations*[1], focusing on the following points: 1) my formulation and summary of the Chapter's main topics, organized into six groups of Paragraphs that I defined within the Chapter; 2) summaries of subtopics addressed in each of the 34 Paragraphs; 3) selected quotations that illustrate the contents of the topics and subtopics; 4) my comments on these quotations; 5) supplementary readings of Winnicott or other authors expanding chapter's themes or related topics; and 6) my own comments. It will be noted that, conceptually, the topics and subtopics are not clearly interconnected, so a straightforward reading this paper does not readily reveal the internal unity of Winnicott's thinking on schizophrenia (nor the central elements of his paradigm), something that my commentary will attempt to mitigate.

The aim of this type of analysis[2] is to offer an anthology of Winnicott's writings on a given subject, accompanied by commentary, to facilitate, as precisely and articulately as possible, the study of their conceptual structure and the parallels found in the remainder of Winnicott's work and in other authors. This study can be conducted on different levels, the complexity of which increases as one descends from the main topics down to the comments on supplementary readings.

The main theme addressed in this text is the theory of schizophrenia, so the published title of the lecture, alluding to a comparison between simple clinical regression and regression to dependence, describes only a small portion of the subject matter.

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[1] This chapter is a lecture by Winnicott delivered to an audience of physicians gathered at a symposium on psychotherapy, organized by McLean Hospital, in Belmont, Massachusetts, in October 1967. During Winnicott's time, this hospital maintained a training program in psychiatric psychotherapy.

[2] The structural analysis proposed here follows the outline of the schemes used in the IBPW Training Course, which we are now developing with the help of the properly trained NotebookLM platform. Another example of this type of structural analysis can be found in Loparic, 2025a.

Beyond this theoretical objective, outlined in topics and further developed in subtopics, Winnicott also seeks to provide a chronological account, albeit partial and summarized, of the development of his ideas on the nature of schizophrenia, by offering something very rare in his writings: explicit references to his earlier texts (see notes 2 to 7 of the Chapter 29). In January 1967, he undertook a similar exercise of combining conceptual analysis and intellectual autobiography in a lecture for the 1952 Club, examining the relationship between his theory of human maturation and other authors formulation of the beginnings of maturational development[3]. Both texts are the result of his attempt to present publicly his reflections on the emergence and articulation of two pillars of his paradigm: the theory of maturation and the theory of schizophrenia[4]. On both occasions, the invitation for Winnicott to speak did not come from a psychoanalytic institution, and the audiences were not composed mainly – if at all – of psychoanalysts. A third, later text from 1971, this time addressed to IPA members, similarly deals with the revolutionary character of his work as a whole. It opens with a request that challenges the traditional psychoanalytic establishment and, in retrospect, is one of the most intriguing aspects of his intellectual and personal life: "I am asking for a kind of revolution in our work" (1971c/2017).

To make the layout more user-friendly, topics will be identified by Roman numerals, subtopics by Arabic numerals, quoted Paragraphs from Chapter 29 by letters beginning with **A**, and fragments of commented quotations by Roman numerals in parentheses.

I. Winnicott states his position: delimitation of the field of his theory of schizophrenia in relation to physical (organic) medicine, academic psychology and Freudian psychoanalysis (Paragraphs A to F)

1. Moving away from the medical hospital management of schizophrenia and indicating an alternative approach to the topic of schizophrenia: treatment of borderline adults

> Paragraph **A**
> **(1)** It is necessary for me to make my position clear at the outset. In this paper I am not starting from specialised clinical experience relative to the hospital management of schizophrenic patients. **(2)** My clinical experience of adult cases must be assumed to be that of a psycho-analyst who, whether he likes it or not, becomes involved in the treatment of borderline patients, and those who perhaps unexpectedly become schizoid during treatment.

Comment: (1) Winnicott positions himself outside the field of hospital psychiatry. **(2)** Here, as in other texts, he signals that he feels compelled to treat cases that traditional

[3] See 1967c/1989.
[4] This was published posthumously in *Psychoanalytic Explorations*.

psychoanalysis would reject as being of the "wrong" type or improperly selected, such as borderline and schizoid cases.

Further readings:

1. A borderline case: the woman who dreamt of a tortoise

> 1962b/1965, pp. 249-250
> **(1)** The trouble was that she had not yet had time in her analysis to deal with reactions to my going away [a trip to U.S.A.], and so she had this suicidal dream, and clinically she became physically ill, though in an obscure way. **(2)** Before I went I just had time, but only just, to enable her to feel a connexion between the physical reaction and my going away. **(3**) 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. **(4)** By killing herself she would gain control over being annihilated while dependent and vulnerable. **(5)** 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; **(6)** and now the physical illness came as a localization in a bodily organ of this total urge to die. **(7)** 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. **(8)** Incidentally her physical illness became less of a threat and started to heal, partly of course because it was receiving appropriate treatment.

Comment: (1) Patient's emotional and somatic reactions to a clinical failure by Winnicott. **(2)** Connection between the physical reaction and the failure, established by interpretation. **(3)** Aetiology and early maturational diagnosis of the emotional reaction. **(4)** Suicide interpreted as a defence against dependence and vulnerability. **(5)** Split within the personality, not in the mind or intellect, between two urgencies: the urge to live and the urge to die. **(6)** Borderline somatic enactment of the urge to die. **(7)** Interpretation of the meaning of this defence organization by a concerned, albeit flawed therapist. **(8)** Provision of appropriate physical treatment.

2. A schizoid case

> 1951/1971, p. 20-21
> This patient … have value.

3. A definitive psychiatric diagnosis is impossible

> 1959-1964/1965, p. 132
> **(1)** 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. **(2)** An hysteric may reveal underlying schizophrenia, a schizoid person

> may turn out to be the healthy member of an ill family grouping, an obsessional may turn out to be a depressive.

Comment: (1) During analysis, new maturation problems may come to occupy the front stage and require being met. Winnicott´s diagnosis takes into account and keeps reinterpreting symptoms of unattended problems that belong to the total history of the patient not just their snapshots. **(2)** Alterations of diagnosis are exemplified by switch from hysteria to schizophrenia typical to borderline cases, discovery of healthy aspects in a schizoid personality and deferent choices of neurotic defences.

4. Treatment of "wrong" cases

> 1962a/1965, pp. 168-169
> **(1)** What about modified analysis?
> **(2)** I find myself working as a psycho-analyst rather than doing standard analysis when I meet certain conditions that I have learned to recognize.
> (a) Where fear of madness dominates the scene.
> (h) Where a false self has become successful, and a facade of success and even brilliance will be destroyed at some phase if analysis is to succeed.
> (c) Where in a patient an antisocial tendency, either in the form of aggression or of stealing or of both, is the legacy of a deprivation.
> (d) Where there is no cultural life – only an inner psychic reality and a relationship to external reality – the two being relatively unlinked.
> (e) Where an ill parental figure dominates the scene.
>
> These and many other illness-patterns make me sit up. **(3)** 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. In this sense I do psycho-analysis when the diagnosis is that this individual, in his or her environment, wants psycho-analysis. I might even try to set going an unconscious co-operation, when conscious wish for analysis is absent. But by and large, analysis is for those who want it, need it, and can take it.
>
> **(4)** When I am faced with the wrong kind of case I change over into being a psycho-analyst who is meeting the needs, or trying to meet the needs, of that special case. I believe this non-analytic work can usually be best done by an analyst who is well versed in the standard psycho-analytic technique.

Comment: (1) In fact, Winnicott will not only propose a modified standard analysis (suited to his paradigm), but also a new technique: care-cure, which treats individuals with maturational difficulties, in contrast to the psychoanalytic talking cure, which attempts to correct mental mechanisms (see 1962c/1989, pp. 73-74). **(2)** There are a number of cases, some of which he lists in the passage cited above, that cannot be efficiently treated, even by a modified

Freudian standard analysis, and are thus considered "wrong" or poorly chosen. Their treatment requires something other than psychoanalysis. **(3)** The choice of therapeutic technique depends on the type of case, as determined by a maturational diagnosis, which identifies maturational needs that were unmet at the appropriate stage. Winnicott's classification of cases differs essentially from the traditional Freudian one; (see 1959-1964/1965, pp. 133-138, (*Positive Suggestions* section) and Loparic, 2026b. **(4)** To deal with "wrong" cases, Winnicott uses management (see 1964a/1989), a procedure that can be carried out not only by professional therapists – analysts, psychiatric social workers, educators or other caseworkers – as well as by "natural therapists" (parents, friends, etc.). On management and its variations, see Loparic, 2025c.

5. At this stage of his work (1965), borderline cases become exemplars for the treatment of mental illness.

> 1965b/1989, p. 122
> **(1)** It is important to state this fact, that the psychoanalytic study madness, whatever that means, is being done chiefly on the basis of the analysis of what are called borderline cases. The advances in the understanding of psychosis are not so likely to come from the direct study of the very severely broken down mad patient. **(2)** The analysts' work therefore at the present time is open to the criticism that what is true of the borderline case is not true of the broken down case or of organised madness. Undoubtedly there will be found to be significant differences between the madness that is sometimes accessible to examination and even treatment in the borderline case and the madness of the case of total breakdown. **(3)** Nevertheless for the time being work must be done that can be done and that can be a natural development of the application of the psychoanalytic technique to the more deeply disturbed aspects of the personalities of our patients.

Comment: (1) The study of borderline disorders is considered the most important and promising avenue for investigating madness – specifically, schizophrenic disorders understood as forms of disintegration. **(2)** Acknowledgement of the difference between borderline disorders and conditions that reveal a breakdown of the self or of the defence organization against such a breakdown (organized madness produced by *active* self-disintegration (see below Paragraph **AD**, further readings 2, comment). On this distinction, see Loparic, 2026c. **(3)** In other texts (see example below), Winnicott makes it clear that the ineffectiveness of traditional psychoanalysis in treating pre-I AM

> disorders, a term I use to refer to psychoses, is not due to an error in case selection, but to the inadequacy of the technique.

6. Difficulties with the term "psychosis"

> 1959-1964/1965, p. 131 note
> **(1)** I realize that the word 'psychosis' presents all manner of difficulties. In a way I am claiming a meaning for the word at a time when there are many who would like to see the word dropped. **(2)** I suggest, however, that there is still a use for this term to cover emotional disorder that is not included in the terms psycho-neurosis or neurotic depression. **(3)** I am aware that in psychiatry the term psychosis is used to describe various syndromes which have a physical basis. Here is another source of confusion. **(4)** I cannot see, however, that anything can be gained from inventing a new word.

Comment: (1) The conflicting uses of the term "psychosis" in the field of health – including in traditional psychoanalysis, as the context of this note suggests – provide good reasons for Winnicott to consider excluding the term altogether from the language of his paradigm. **(2)** He refrains from doing so and proposes a new meaning for the term more in line with his own classification of maturational disorders. I attempt to capture this meaning with the expression "pre-I AM disorders", reserving the expression "post-I AM", also with a Winnicottian flavour, to refer to reactive depressions and neuroses, understood in the maturational sense. **(3)** Again, Winnicott distances himself from the language of physical psychiatry, another source of disagreement. **(4)** Here I depart from Winnicott and propose a new neologism, based on one of his own (I AM), which follows his characteristic way of using words and may, perhaps, have a chance of acquiring an idiomatic status in his conceptual lexicon.

7. A historical note on the crisis of traditional technique

> 1959-1964-1965, pp. 125
> **(1)** Gradually and in the course of time the study of psychosis began to make more sense. Ferenczi (1931) contributed significantly by looking at a failed analysis of a patient with character disorder not simply as a failure of selection but as a deficiency of psycho-analytic technique. **(2)** The idea implied here was that psycho-analysis could learn to adapt its technique to the character disorder or the borderline case without turning over into management, and indeed without losing the label psycho-analysis.

Comment: (1) Ferenczi attributes Freud's refusal to treat character disorders to the shortcomings of standard analysis. **(2)** According to Winnicott, who would dare take this revolutionary step, Ferenczi believed it was possible

to adapt the standard technique to treat not only character disorders but also borderline ones, without *turning the analytic process into management* and without having to relinquish the designation of psychoanalysis, a revolutionary step that Winnicott would dare to take.

2. A second approach to the domain of schizophrenia: treatment of childhood schizophrenia (autism), a part of child psychiatry reformulated by Winnicott

Paragraph **B**
In my child psychiatry practice, however, I have had all types of case in my care, and have watched autism or schizophrenia of childhood develop, and this perhaps justifies me in accepting this invitation, which I feel to be an honour.

Comment: Child schizophrenia is Winnicott´s theory of maturational problems usually labelled "autism".

Further readings:

1. The Ashton case

1965a/1989, p. 144
There were traumata in this boy's very early infancy which the parents could not prevent, but which did in fact nearly cause him to be a case of infantile schizophrenia. Instead he developed into a schizoid person, a person who increasingly needed to try to solve one problem. This and other similar problems would have lain hopelessly unsolved in him if he had become an infantile schizophrenia case, or perhaps one of those odd mental defectives who show patchy intellectual brilliance.

Comment: Confronted by a very early problem of simultaneous acceptance and refusal of the mother, yet helped by Winnicott and parents, Ashton avoided developing child schizophrenia (active multiplication of problems and subsequent disintegration of the self) or becoming mentally defective as a defence. Instead, counting also on his high intelligence mobilized by his false self, he developed healthy aspects of personality, turned himself into a schizoid and became able to concentrate on his one basic problem and to go on solving it. See also the Bob case, 1971a, case IV.

2. Jung's childhood schizophrenia: Winnicott's diagnosis based on Jung's autobiography

1964b/1989, p. 483
Jung, in describing himself, gives us a picture of childhood schizophrenia, and at the same time his personality displays a strength of a kind which enabled him to heal himself. At cost he recovered, and part of the cost to him is what he paid out to us, if we can listen and hear, in terms of his exceptional insight. Insight into what? Insight into the feelings of those who are mentally split.

Comment: This a vibrant personal and intellectual tribute to Jung, which reveals the profound Winnicott´s debt to him as a human figure and as a thinker. A similar homage from the same period can be found in 1963a/1965, p. 190.

3. The importance of studying Jung's autobiography

> 1964b/1989, p. 482
> The publication of this book [*Memories, Dreams, Reflections*, Jung´s autobiography] provides psychoanalysts with a chance, perhaps the last chance they will have, to come to terms with Jung. If we fail to come to terms with Jung we are self-proclaimed partisans, Partisans in a false cause. […]
>
> By "this book" I mean the first 115 pages. These first three chapters are genuine autobiography. Here is an autobiography to take its place with the other really convincing autobiographies; one has no doubt about the value of these chapters as a truly self-revealing statement. My review will concern itself with these important chapters, and mostly with the first chapter: "First Years."
>
> I am sure that *every psychoanalyst must read* these first three chapters and so meet Jung as he was, and that no analyst who has failed to read them is qualified to talk or write about Jung and Freud and their meeting and their ultimate failure to understand each other.

Comment: Winnicott implicitly acknowledges that Jung and Freud are separated by what we may call *irreconcilable paradigms* (see also 1964b/1989, pp. 484 and 488). Insofar as there are good reasons to think that Winnicott's theory of schizophrenia has strong Jungian traits, it is reasonable to assume that the same problem of reconciliation exists between Winnicott's paradigm and Freud's (see Loparic, 2025b).

4. Childhood schizophrenia masked by borderline defence

> 1966c/1996, p. 204
> I think of a boy whose full intelligence only showed in regard to his knowledge of what used to be called Bradshaw.' In other respects he was somewhat restricted intellectually. He was a borderline case in that eventually he became able to make a living out of knowing all that was to be known about the running of every train in the United Kingdom. His skill was such that his colleagues put up with his awkward temperament in order to have amongst themselves a living and always up-to-date railway timetable. There is no need for me to continue in this vein because the fact of these specialities is well known and there seems to me to be no sharp line between the speciality that cannot be socialized and the one which makes a man or woman famous. There can be no essential difference in quality between the normal and the abnormal here; all one can say is that in the autistic child the specialization is boring in that it is like rocking and head-banging, a compulsive activity that at its worst seems to be devoid of fantasy.

Comment: On classification of borderline cases, See Loparic, 2026c.

5. More on the sources of Winnicott´s ideas.

> 1963b/1965, p. 235
> *Sources of My Personal Ideas*
> […] **(1)** For my part, I have had much opportunity as a paediatrician to observe infants with their mothers, and have made a point of getting innumerable mothers to describe their infants' way of life in the early stages before the mother has got out of touch with these intimate things. (If I had my time again I would work with premature infants, but this has not been possible.) **(2)** Then I have had a personal analysis which took me back into the forgotten territory of my own infancy. **(3)** This was followed by the psycho-analytic training, and my basic training cases took me to early infantile mental mechanisms as displayed in dreams and in symptoms. Child analysis gave me a child's view of infancy.
>
> Then I came to the analysis of patients who proved to be borderline, or who came to have the mad part of them met and altered. It is work with borderline patients that has taken me (whether I have liked it or not) to the early human condition, and here I mean to the early life of the individual rather than to the mental mechanisms of earliest infancy.

Comment: (1) Winnicott´s paediatric clinical experience consists in observing nursing couples in terms of the theory of maturation and maturational pathology and in history taking based on mothers´s reports on early ways of life of their babies. **(2)** Personal analysis including auto-analysis (see Loparic, 2025b). **(3)** Training in finding mental mechanisms revealed in doing traditional child analysis. **(4)** Work with adult borderline patients who reveal that the early ways of life of human beings are not mental activities generated by mental mechanisms. This quotation taken together with previously commented paragraphs of the Chapter 29 helps us to understand why borderline patients, schizoid personalities and schizophrenic children are the three main pathological categorise in Winnicott´s maturational pathology in general, not just in the group of pre-I AM disorders.

4. The theoretical character of the Chapter 29

> Paragraph **C**
> **(1)** I need to be allowed to wander around in the theoretical field, unburdened by the caseload which belongs to practice rather than to the conference table. **(2)** We can adopt this course, I believe, without cutting ourselves off from the source of our work, which must always be the human beings who come to us or who are brought, because of life's difficulties.

Comment: (1) Emphasis on the theoretical, rather than clinical nature of this lecture to psychiatrists, suggesting an implicit recognition that psychoanalytic theory may be discussed by people not trained in psychoanalytic practices. **(2)** The purely theoretical discussion is justified by the fact that, ultimately, professional clinical material reveals difficulties of human

existence common to all. I will provide examples of this material in the supplementary readings below.

5. The aubiographical and pedagogical features of the text

> Paragraph **D**
> **(1)** It seemed to me to be a good idea to use this opportunity to sort out a little for myself the inter-relation of two ideas, one of schizophrenia as a regression, and the other of schizophrenia as a defence organisation. **(2)** It might happen that in practising my scales and arpeggios in this way I may provide material for discussion. **(3)** I am not concerned either with being original or with quoting from other writers and thinkers (or even Freud).

Comment: (1) Winnicott states autobiographical relevance of the theme announced in the title. **(2)** A bit of theoretical training in his clinical theory as an invitation to discussion. On the metaphor of scales and arpeggios, (see 1971a, p. 6). **(3)** Winnicott aims to discuss his ideas, not to be recognized as an independent thinker or as a follower of other authors, including Freud. Nevertheless, in the chapter he will clearly identify points which are original and even revolutionary.

6. Distancing from physical medicine

> Paragraph **E**
> For the sake of those whose work takes them in the direction of the physical treatments, may I say that I shall ignore these here, simply because whatever is known or will be discovered about the biochemistry or the neuropathology or the pharmacology relative to schizophrenia, there will still be the patients there, persons like ourselves, with a history in each case of the onset of the disorder, and with a load of personal striving and suffering, and with an environment that is simply bad or good or else confusing to a degree that can be bewildering even to relate.

Comment: At this point, Winnicott revisits Freud's positions in *The Question of Lay Analysis* regarding organic medicine.

7. Distancing from academic psychology in all its aspects

> Paragraph **F**
> What I have to say, therefore, will be neither for nor against the specialist in the physical aspects of the disorder; and if I fail to refer to the work of the pure or academic psychologist, here also I must be understood to be, quite simply, busy elsewhere.

Comment: Also on this issue Winnicott stands with Freud.

II. The basic assumptions of Winnicottian pathology: elements of the theory of maturation (Paragraphs G to J)

1. Introductory presentation of the theory of maturation

> Paragraph **G**
> To examine the theory of schizophrenia one must have a working theory of the emotional growth of the personality. This is in itself so vast a matter that I could not

possibly do it justice in a brief review. What I must do is to assume the general theory of continuity, of an inborn tendency towards growth and personal evolution, and to the theory of mental illness as a hold-up in development. This last item carries with it the idea of a dynamic towards cure - that is, if a block to development is removed then growth follows because of powerful forces belonging to the inherited tendencies in the individual human being.

Comment: The inherited trends will be discussed and illustrated through the quotations below.

2. Contrast to the approach to maturation in terms of the theory of sexuality and the Oedipus complex

Paragraph **H**
Also, I can say that the statement of infantile and child development in terms of a progression of erotogenic zones, that has served us well in our treatment of psychoneurotics, is not so useful in the context of schizophrenia as is the idea of a progression from dependence (at first near-absolute) towards independence—a subject that I have dealt with at some length in various papers.

Comment: Opposition to treating maturational problems in terms of the theory of sexuality.

Further reading:

The Oedipus complex no longer at the centre stage

1969b/1989, p. 246
(1) To make progress towards a workable theory of psychosis, analysts must abandon the whole idea of schizophrenia and paranoia as seen in terms of regression from the Oedipus Complex. The aetiology of these disorders takes us *inevitably* to stages that precede the three-body relationship. **(2)** The strange corollary is that there is at the root of psychosis an external factor. **(3)** It is difficult for psychoanalysts to admit this after all the work they have done drawing attention to the internal factors in examining the aetiology of psychoneurosis.

Comment: (1) This is a different wording of one of the main theses of the Chapter 29. **(2)** Indirect allusion to one of the central features of Winnicott´s paradigm shift: denial of the central position in the theory of maturation and in pathology to three-body relationships, that is to say triangular (Oedipal) relationships, and the admission of the two-body or dual relationships as basic at the pre-I AM stages, where there is danger disintegrative interruption of the maturational processes resulting in defences that characterize schizophrenia and paranoia. **(3)** An interesting point of Winnicott´s on reasons for inertial residence to paradigm change against empirical evidence in its favour.

3. Importance of environmental provision in the maturational process

Paragraph **I**
Here we pay full tribute to the environmental provision, for instance, to the nature of the mother in her presentation of the world to her infant who knows nothing else. At the beginning the environmental factor may be allowed full value, second only to the inherited tendencies of the infant. As the child acquires autonomy and acquires an identity and feels real and perceives the environment objectively as a separate phenomenon, so the environment becomes (in health) increasingly relegated to second place, except that in illness—such as schizophrenia—it always has to be remembered that *the environment may continue to be an adverse factor because of the individual's failure to obtain sufficient autonomy*.

Comment: On disruptive elements in family life, see 1959/1965, in particular the Anthony case.

Further reading:

Critique by other authors of the use of the Oedipus complex, cited in the January 1967 lecture mentioned in the Introduction.

1967a/1989, p. 569
Protest against reference to universal regression from Id satisfaction-frustration in Oedipal triangle.
Alice Balint, Ribble, Suttee, Lowenfeld.

4. Essential character of the theory of maturation

Paragraph **J**
It would not be possible to go further into the essential theory of personal development here and now, although nothing could be more relevant to the theme.

Comment: Forceful statement on the theory of maturation as the guiding-generalization of the paradigm.

Further reading:

Winnicott´s only companion

1971a, p. 6
The only companion that I have in exploring the unknown territory of the new case is the theory that I carry around with me and that has become part of me and that I do not even have to think about in a deliberate way. This is the theory of the emotional development of the individual which includes for me the total history of the individual child's relationship to the child's specific environment.

Comment: Winnicott´s research on clinical cases of children, and we can safely say of patients of all ages, is based on a theory that includes, in addition to the study of emotional development, the history of all aspects of the individual-environment set-up.

III. Elements of Winnicottian pathology: classification of maturational disorders by diagnosis Paragraphs K to Q)

1. Disorders arising from conflict

> Paragraph **K**
> For me, the clue to the conflict that underlies illness that we label psycho-neurosis lies within the individual. The analyst of the psychoneurotic patient is involved, as is well known, in the analysis of the patient's repressed unconscious.

Comment: The conflict that underlies psycho-neurotic defence organizations is that of between love and hate of father or of mother, in other words the emotional ambivalence as regards the same central family member, which generates intolerable anxiety and leads either to repressing of parts of the stream of conscious emotional life if not of earlier maturational acquisitions or to psychoneurosis.

2. Pre-I AM disorders are conceived as resulting from extreme dissociation or splitting of the personality

> Paragraph **L**
> By contrast, where schizophrenia lies, the analyst or whoever is treating the patient or managing the case is involved in elucidating a split in the patient's person, the extreme of a dissociation. *The split takes the place of the repressed unconscious of the psychoneurotic*.

Comment: This conception of schizophrenia, which is at the heart of Winnicott's article, is one of the most important of his paradigm. The split is said to occurs in the patient person not in the mind, which implies strictly speaking that schizophrenia is not a "mental" disorder, but a personality breakdown related to environmental mal functioning in very early stages of life. This kind of breakdown characterizes a specifically Winnicottian kind of unconscious which consist in the condition that "the ego integration is not able to encompass something", because it is "too immature to gather all the phenomena into the area of personal omnipotence" (1963c/1989, pp. 90-91). This form of interruption of the tendency towards integration and its origins, which occurs totally outside the stream of consciousness and is not made of repressed fragments of it – which may a good reason for not calling it unconscious at all (see Loparic, 2001) – will be examined in the comments on Paragraph **M** and on the further readings. For a classification of maturational disorders formulated within the Winnicottian paradigm, see 1959-1964/1965, section *Positive Suggestions*. On the classification of borderline disorders, see Loparic, 2026b.

Further reading:

Schizophrenia as the splitting of the personality

> 1953/1987, p. 50
> **(1)** It would almost seem as if you have not yet met someone fundamentally split. **(2)** The gentleman who invented the word schizophrenia really did believe in the splitting of the personality, whereas it seems to me that you have got as far as seeing that a person who is whole can be concerned with dissociated elements in the inner and external world. (3) I think this is rather an important point in view of the fact that in your use of the word splitting you are joining in with the current tendency […] of the Klein grouping. In making this suggestion I was voicing the opinion usually unexpressed, of a large number in the Society.

Comment: (1) Winnicott suspects that Esther Bick is unaware of symptoms of basic splitting, that of the personality. **(2)** The "gentleman" she mentions is clearly Eugen Bleuler, founder of the Zurich School of Psychiatry, dedicated to the study of schizophrenia. Winnicott sides with Bleuler and argues against Bick (and the Kleinians), who apparently recognize only the dissociation between elements of the patients' internal and external worlds. In 1900, Jung became Bleuler's assistant and collaborator at the Burghölzli hospital, and worked actively with him in advancing research.

3. Basic split and the sub-total split

> Paragraph **M**
> **(1)** I have tried to clarify my ideas on this theme particularly in 'Psychoses and Child Care'. **(2)** Here I give a diagram of my idea of the basic split in psychotic illness, **(3)** but clinically the split, being sub-total, may appear in various forms of dissociation, such as True Self and False Self and the intellectual life split off from psycho-somatic living.

Comment: (1) The importance of the 1952 text for the development of Winnicott´s views on schizophrenia. **(2)** In the 1952 diagram, the *basic split* that characterizes schizophrenia is represented by a bold curve dividing an unspecified area in two equally indeterminate subareas. As will be clarified in the further readings below, this split does not take place in the individual's personality, but in the *environment-individual set-up*, where "environment" refers to pre-objective environment-mother. This point should be related to Winnicott´s 1948 thesis that "schizophrenia is a sort of environmental deficiency disease" (1948/1958, p. 162; see also 1959-1964/1965, pp. 135-136). **(3)** Although the basic split itself does not appear as such in everyday life or in clinical material, it manifests itself in varying degrees of dissociation (or disintegration, 1988, p. 120), the extreme form of which is the sub-total split *of the personality* between the spontaneous and creative true self (which exerts control over the secret subjective

world) and the false self (which relates to the external world by being submissive and compliant and is enclosed within the objectively perceived world).

Further readings:

1. The basic total unit

> 1988, p. 131
> In this stage [the stage of the primitive state of being] the unit is the *environment-individual setup* (or whatever it can better be called) of which unit the new individual is only a part. At this very early stage it is not logical to think in terms of an individual, and this is not only because of the degree of dependence, and not only because the new individual has not yet the power to discern environment, but also because there is not yet an individual self there to discriminate between ME and not-ME.

Comment: The individual exists here only as a potential later achievement.

2. The essential split in human nature

> 1988, p. 136
> **(1)** Splitting is an essential state in every human being, but one that need not be significant if the cushioning of illusion is made possible by the mother's management. **(2)** In absence of active adaptation that is good enough the splitting becomes significant, with the following result:
> A. Root of true self, with spontaneity, related omnipotently to subjective world, incommunicable, and
> B. False self-related on compliance basis (without spontaneity) to what we call external reality.
> **(4)** Gradually, as development proceeds, the individual can encompass the splitting that exists in the personality and then lack of wholeness is called dissociation.

Comment: (1) This essential state is the splitting between being spontaneous, omnipotent and creative in the subjective world and relating to the external world in reactive, submissive and imitative ways. This going-on-splitting is not produced by a particular external impingement or pattern of impingements, but by the very fact that the external world exists and goes on existing, whether the baby creates it or not, which is that what Winnicott calls the Reality Principle and sees as the "arch-enemy of spontaneity, creativity and the sense of Real" (1961/1986, p. 106). Although an unavoidable "principle" of living, this fact is experienced as an insult, a lack of respect to spontaneity and creativity of the self-processes. If cushioned by the environment, if it ensures the illusionary experience of omnipotence, this essential state does not generate pathological effects. In the stage of transitional phenomena, for instance, the baby acquires "genetically determined mental mechanisms for coping with this

insult" (1970a/1986, p. 40). At that stage of the maturation process activities of the individual baby are controlled by operational centres located in the true or the false self both rooted in and develop form in this essential state even before the full inclusion of the self´s core to the total I (see 1954/1958, p. 292). **(2)** In the absence of sufficient environmental provision, however, it results in the pathological splitting into two partes of the personality, which means that these two parts do not communicate. **(3)** As maturation progresses, the individual may achieve a level of integration sufficient to contain the splitting that derives from the insult. This is achieved by the true self within the potential space, where the interplay between "there is nothing but me and there are objects and phenomena outside omnipotent control" (1988, p. 118) takes place. This space provides the foundation of cultural experience, but again if the environment fails, if this space is not produced, the basic cleavage between what is subjectively conceived and objectively perceived appears in the form of a pathological dissociation between the true and false selves. In extreme cases, these two ways of life remain incommunicable.

3. Two mechanisms for coping with the insult by the Reality Principle: compliance and creative omnipotence

> 1970a/1986, p. 40
> I am ready to describe some of these mental mechanisms.
>
> Given good-enough environmental conditions, the individual child (who became you and me) found ways of absorbing the insult. Compliance, at one extreme, simplifies the relationship with other people who, of course, have their own needs to attend to, their own omnipotence to cater for. At the other extreme the child retains omnipotence in the guise of being creative and having a personal view of everything.

Comment: These two kinds of defence mechanisms (submission and persistent omnipotence) are operated as said by the false self and the true self, respectively. Both function as agencies where the operational centre of the maturational processes is located (see 1954/1958, p. 295). The former relinquishes any claim self-respect; the latter, intensifies it.

4. The tendency for a basic split in the environment-individual set-up, and the capacity to sacrifice spontaneity and die

> 1952/1958, p. 224
> In Fig. 15 I try to show how a tendency for a basic split in the environment-individual set-up can start through failure of active adaptation on the part of the environment at the beginning.

Comment: The tendency toward splitting in the environment-individual set-up is defensive in nature and originates in the failure of the environmental component of the set-up to provide conditions for the spontaneous gesture and the illusion of omnipotence (see the bubble metaphor in 1988, p. 127). As previously noted, the split manifests both in lived experience and clinically as a dissociation within the individual, as the sub-total split between the true and the false selves (see 1970a/1986, p. 40). Moreover, even a good-enough environment may sustain relationships that lead to different kind of undoing of integration, one in which the individual may "at times disintegrate, depersonalise and even for a moment abandon the almost fundamental urge to exist and to feel existent" (1970b/1989, p. 261). This "restful undoing" of the integrative processes and of all of their results is, in itself, a capacity of a self (Winnicott does not specify whether the true or false self) "that can eventually even afford to sacrifice the spontaneity, even, to die" (1956/1958, p. 304) – meaning going back to the state of non-being and even non-living, out of which living and later on being arise (1988, p.132).

5. Disintegration brought about and established as a tendency by anxiety around wholeness

> 1988, p. 137
> Disintegration after the individual has attained unit status is an organised undoing of integration, brought about and maintained because of intolerable anxiety in experience of wholeness. The splitting up in disintegration occurs along lines of cleavage in the inner world setup, or of perceived outer world cleavage.

Comment: Wholeness means absence of space for anything outside of it and for the split between the subjective and the objective. This represents an extreme and intolerable objectification of the self.

6. The basic value: living creatively

> 1966d/1971, pp. 99-100
> **(1)** What I say does affect our view of the question: what is life about? **(2)** You may cure your patient and not know what it is that makes him or her go on living. […] **(3)** Psychotic patients who are all the time hovering between living and not living force us to look at this problem, one that really belongs not to psychoneurotics but to all human beings. **(3)** I am claiming that these same phenomena that are life and death to our schizoid or borderline patients appear in our cultural experiences. It is these cultural experiences that provide the continuity in the human race that transcends personal existence. **(4)** I am assuming that cultural

> experiences are in direct continuity with play, the play of those who have not yet heard of games.

Comment: (1) In Winnicott the question of the purpose of life is at the core of the question of health. Life is not merely a matter of not being ill, but also – and more directly – of feeling real, which implies being spontaneous and creative. To pursue health in terms of being free from illness, of remaining sane and aligned with the Reality principle, is not what makes life worth living; on the contrary, it is an insult to life. **(2)** Psychotics patients are those who are ill precisely because they do not feel real. It is they, not the psychoneurotics, who compel us "healthy" individuals to feel insulted by the Reality Principle and to raise the fundamental questions of being and non-being, of living and dying – in short, questions of the value of life. **(3)** These same questions arise in one's cultural life and each of us answers them through the products of spontaneous and creative activities in our personal transitional space. **(4)** These experiences are rooted in modes of being that are direct developments of playing. We find here the essential meaning of the title *Playing and Reality*.

7. Tendency to a split ending up in latent schizophrenia concealed by the false self

> 1952/1958, p. 225
> **(1)** Where there is a high degree of the tendency to a split at this early stage, the individual is in danger of being seduced into a false life, and the instincts then come in on the side of the seducing environment. […]. **(2)** A successful seduction of this kind may produce a false self that seems satisfactory to the unwary observer, although the schizophrenia is latent and will claim attention in the end.

Comment: (1) Submission may become a tendency, both defensive and dangerous, insofar as it impedes spontaneous and creative living, because a submissive and compliant life is organised around emerging instinctual impulses of various kinds. **(2)** The false life may fall under the control of the false self, which presents itself as the true one, but which, in the case of latent schizophrenia, will eventually falter.

4. One aspect of the aetiology of dissociations stands out: pathological expectations of the environment

> Paragraph **N**
> Obviously the nature of the dissociation that appears clinically may be influenced by the nature of expectations from the environment, so that a patient may be suffering from pathological expectations in the environment. The parents may have wanted a child of the other sex, for instance, or may have wanted a genius or a child that has no aggressive

impulses. These pathological expectations can reinforce potential dissociations in the individual.

Further reading:

Maternal pathogenic expectations (the FM case)

1966a/1989, p. 171
This complex state of affairs has a special reality for this man because he and I have been driven to the conclusion (though unable to prove it) that his mother (who is not alive now) saw a girl baby when she saw him as a baby before she came round to thinking of him as a boy. In other words this man had to fit into her idea that her baby would be and was a girl. (He was the second child, the first being a boy.) We have very good evidence from inside the analysis that in her early management of him the mother held him and dealt with him in all sorts of physical ways as if she failed to see him as a male. On the basis of this pattern he later arranged his defences, but it was the mother's "madness" that saw a girl where there was a boy, and this was brought right into the present by my having said "It is I who am mad." On this Friday he went away profoundly moved and feeling that this was the first significant shift in the analysis for a long time (although, as I have said, there had always been continuous progress in the sense of good work being done);

Comment: A detailed analysis of the FM case can be found in Loparic (2025a, sections 3 and 7). A catalogue of Winnicott's clinical material – including cases, vignettes, dreams, and exemplars – can be found in Silva, 2026). The classification of material catalogued in Silva (2026) is provided in Loparic (2026d).

IV. Towards aetiology of schizophrenia (Paragraphs O to X)

1. Notice on the presentation of lesser-known material

Paragraph **O**
All this is well known and well accepted. What follows is less sure, but I shall continue to use dogmatic language.

Comment: Winnicott is referring to his ideas presented in the texts cited in notes 2 to 4 of Chapter 29. One may have doubts if these ideas were really part of the mainstream psychoanalytic thinking. What follows is mainly the exposition of his ideas developed in his still unpublished papers starting with "Fear of breakdown" (1963c/1989).

2. The very idea of the aetiology of schizophrenic splitting

Paragraph **P**
The split in the person happened and became organised because of an environmental failure. There was a failure of the 'average expectable environment'. In my terms a baby is usually cared for by a 'good enough' mother. Well, either the good-enough mother

had to fail (perhaps she got ill) or else she was not good enough. I am not apportioning blame, only searching for aetiology.

Comment: Statement of the central theme of Winnicott´s maturational aetiology

3. Extension of the concept of schizophrenia to all stages of human life

Paragraph **Q**
These matters are more obviously applicable to infantile and childhood schizophrenia, but we must find a way of applying them to the schizophrenia of adolescent and of adult persons, even when, as it seemed, things went well in early childhood, and the disorder only showed clinically at a later age. The fact is that early dependence continues to have meaning, especially in adolescence, and perhaps in a disguised way throughout life. (Example, dependence on a religious tenet might not show unless some experience should make that tenet untenable.)

Further reading:

The three types of aetiological factors: environmental states, defences, and heredity.

1959-1964/1965, p. 137
In the case of any individual at the start of the process of emotional development there are three things: At one extreme there is heredity; at the other extreme there is the environment which supports or fails and traumatizes; and in the middle is the individual living and defending and growing. In psycho-analysis we deal with the individual living, defending and growing. In classification, however, we are accounting for the total phenomenology and the best way to do this is first to classify the environmental states; then we can go on to classify the individual's defences, and finally attempt to look at heredity. Heredity, in the main, is the individual's inherent tendency to grow, to integrate, to relate to objects, to mature.

4. Elaboration on the aetiology of schizophrenia of early stages

Paragraph **R**
For me, a good-enough mother and good-enough parents and a good-enough home do in fact give most babies and small children *the experience of not having ever been significantly let down.* In this way average children have the chance to build up a capacity to believe in themselves and the world—they build a structure on the accumulation of introjected reliability. They are blissfully unaware of their good fortune, and find it difficult to understand those of their companions who carry around with them for life experiences of unthinkable anxiety, and a deficit in the department of introjected reliability. It is among these latter persons that illness, when it occurs, tends to take a form that we label schizophrenic rather than psychoneurotic or depressive.

5. Note on the idea of trauma

Paragraph **S**
I have to insert a note here, in spite of my determination to keep out everything that is not needed for the exposition of my main theme; this has to do with the fact that failures in environmental reliability at the early stages produce in the baby fractures of personal continuity, because of reactions to the unpredictable. These traumatic events carry with them unthinkable anxiety, or maximal pain.

Comment: A brief note on the idea of trauma. This theme will be revisited in Paragraphs **AB**, **AC**, and **AD**. This note sets up the correction of the diagnostic error regarding schizophrenia acknowledged in the following Paragraph.

6. Renewed distancing from traditional psychoanalysis

> Paragraph **T**
> Here I come to the point where I have to confess that I did at one time think of schizophrenia and schizoid types of clinical disorder as regressions, so that I joined in the hunt for fixation points. This was a carry-over from the corresponding witch-hunt in the attempt to state the aetiology of psycho-neurosis in its various manifestations.

Comment: This error, which consists in conceiving schizophrenia and schizoid states as regression to fixation points, will be corrected in the following Paragraphs

V. Theory of regression (Paragraphs U to X)

1. Discovery of two forms of regression

> Paragraph **U**
> My attitude changed when I saw that I must think of two kinds of regression-one is simply a falling back in a direction that is the opposite to the forward movement of development. One sees regressive features appearing, and one recognises that the growth mechanisms of the individual have become blocked. The other type of regression is quite different, although it may be similar clinically. In the second type the patient regresses because of a new environmental provision which allows of dependence.

Comment: Radical changes in the diagnosis and aetiology of schizophrenia, central for the understanding of the chapter.

2. A vignette about regression to a naturally enabling environment

> Paragraph **V**
> I am reminded of a lady, not very unusual, who kept going fairly well, in spite of much anxiety and sleeplessness, until she at last found a good reliable housekeeper; at this point she retired to bed, and luxuriated, as the saying is. Substitute 'mental nurse' for 'housekeeper', and then 'luxuriate' becomes a 'schizoid depression' plus the money to pay for it.

Comment: Regression to dependence may be facilitated by figures of the facilitating environment who are not professional therapists and who help the individual through stages of recovery not by using resources of the taking-cure but by proving ingredients of the care-cure.

> **Further reading:**
>
> A vignette: a poet finds a place to live
>
> > 1966b/1987, p. 6
> > My friend the poet, who was very tall and indolent and always smoking, walked down a terrace till he saw a house that looked friendly. He rang the bell. A woman came to the door and he liked the look of her face. So he said: "I want lodgings here." She said: "I have a vacancy. When will

> you be coming?" He said: "I have come." So he went in, and when he was shown the bedroom he said: "It happens that I am ill, so I will go straight to bed. What time can I have tea?" And he went to bed and stayed in bed for six months. In the course of a few days we had all settled in nicely, but the poet remained the landlady's favourite.
>
> **Comment:** There is a lot of nonverbal communication and management in this episode. See Winnicott´s analysis of the Paragraph **V** and my comment.

3. Summary of the discovery: establishment the new concept of regression as a central element in the diagnosis of schizophrenia.

> Paragraph **W**
> In other words, I found that in my study of schizoid phenomena I was using the word 'regression' to mean *regression to dependence.* I did not any longer care whether the patient had stepped back in terms of erotogenic zones.
>
> **Comment:** Reiteration of the rejection of diagnoses elaborated within the sexual paradigm.
>
> **Further reading:**
>
> Two types of regression
>
> > 1989, p. 44
> > Regression (to dependence)
> > (**1)** The term "regression" is applied ordinarily in psychoanalytic writings to instinct positions. Regression is from genital to pregenital erotic experience or fantasy, or it is to fixation points belonging to the life of infancy in which pregenital fantasy is naturally dominant.
> > **(2)** Regression is also a convenient term for use in description of an adult's or a child's state in the transference (or in any other dependent relationship) when a forward position is given up and an infantile dependence is reestablished. Typically, regression of this kind is from independence to dependence. In this use of the term the environment is indirectly brought in since dependence implies an environment that meets dependence. By contrast, in the other use of the term "regression" there is no implied reference to an environment. (3) The term "regression" is also used to describe the *process* that can be observed in a treatment, a gradual shedding of the false or caretaker self, and the approach to a new relationship in which the caretaker self is handed over to the therapist.
> >
> > **Comment: (1)** Received meaning of regression as a *state* that appears in psychoneurotic transference. **(2)** A brief outline of psychotic transference (see Paragraph **X**). **(3)** Regression as a process of undoing of the false self kind of defences.

4. A new discovery: healthy elements in the regression to dependence present in psychotic transference.

> Paragraph **X**
> **(1)** This led me to see that the patient's illness is an expression of the *healthy* elements in his or her personality, when regression is related to environmental provision. What I mean is that it is one thing if a patient simply breaks down, and it is another thing if a patient breaks down into some new environmental provision that offers reliable care. **(2)** A special example is that of the schizoid patient who goes through a regressive phase because the long preparatory phase of the analysis has given him or her a sense of there being something trustworthy that can be used positively. **(3)** It is true that the use the patient makes of this new opportunity for dependence is complex; nevertheless the work done and the use made of the work done indicates the operation of a healthy 'observing ego' element in the patient. **(4)** The false self-defence can be dropped and the true self can become exposed (at great risk) in the psychotic transference.

Comment: (1) Restatement of the distinction introduced in Paragraph **U** in terms of health and ill-health. **(2)** Specification of the preparatory phases for a healthy regression to dependence. **(3)** An ego structure is already present and operative. **(4)** This structure makes it possible to relinquish the false-self defence, typically mobilised by borderline patients. This process exemplifies a general feature of "psychotic transference", an expression that may be understood as another description of regression to dependence.

VI. Elements of the theory of schizophrenia as a defence organization against unthinkable agonies (Paragraphs Y to AF)

1. Reiteration of the central thesis: schizophrenia is a sophisticated defence mechanism, with particular emphasis on borderline pathology

> Paragraph **Y**
> **(1)** From here (and I am ashamed to have condensed what I mean to the point almost of absurdity) I began to see schizophrenia and especially the illness of the borderline case as a *sophisticated defence organisation.* **(2)** Here is a direct link with Freud, and his central theme, that symptoms mean something and have value to the patient, although he was at first referring to psycho-neurotic manifestations.

Comment: (1) Sketchy allusion to his previous research. **(2)** A rare remark on a point by Freud.

Further readings:

1. Definition of psychosis

> 1963c/1989, p. 90
> It is wrong to think of psychotic illness as a breakdown, it is a defence organisation relative to a primitive agony, and it is usually successful (except when the facilitating environment has been not deficient but tantalising, perhaps the worst thing that can happen to a human baby).
>
> **Comment:** See above for reservations regarding the term "psychosis".

2. Definition of borderline personality disorder

> 1968/1989, pp. 219-220
> **(1)** It is in the analysis of the borderline type of case that one has the chance to observe the delicate phenomena that give pointers to an understanding of truly schizophrenic states. **(2)** By the term "a borderline case" I mean the kind of case in which the core of the patient's disturbance is psychotic, but the patient has enough psychoneurotic organisation always to be able to present psychoneurosis or psychosomatic disorder when the central psychotic anxiety threatens to break through in crude form. In such cases the psychoanalyst may collude for years with the patient's need to be psychoneurotic (as opposed to mad) and to be treated as psychoneurotic.

Comment: (1) The genuinely schizophrenic states under discussion are not aspects of schizophrenic defence organizations, but rather traumatic states – specifically, the effects of reactions to environmental impingement, against which defences such as active disintegration and the "caring self" are erected. **(2)** When the anxieties that accompany these states break down these defences, the patient resorts the false self that mobilizes resources acquired in stages subsequent to the breakdown, such as the capacity to experience internal conflicts, This results in a symptomatology that conceals the breakdown in vestiges of internal conflict (neurosis, for example).

2. Winnicott's of clinical research trajectory from the theory of autistic defences to the general theory of defences of personal integrity, including those produced by schizophrenics.

> Paragraph **Z**
> **(1)** Contributory to my move in this direction of theoretical understanding (a slow move it may be thought) was my wide experience of what I always called childhood schizophrenia. What we observe in children and in infants who become ill in a way that forces us to use the word 'schizophrenia', although this word originally applied to adolescents and adults, what we see very clearly is an *organisation towards invulnerability.* Differences must be expected according to the stage of the emotional development of the adult or child or baby who becomes ill. **(2)** What is common to all cases is this, that the baby, child, adolescent or adult *must never again experience* the unthinkable anxiety that is at the root of schizoid illness. **(3)** This unthinkable anxiety was experienced initially in a moment of failure of reliability on the part of the environmental provision when the immature personality was at the stage of absolute dependence.

Comment: (1) The paragraph provides a valuable piece of intellectual autobiography, assigning a new meaning to the word "schizophrenia" applicable to any age of life: organization towards invulnerability. **(2)** Statement about what the schizophrenic defence is supposed to achieve. **(3)** A note on aetiology.

3. Detailed explanation of autistic defence mechanisms

> Paragraph **AA**
> The autistic child who has travelled almost all the way to mental defect is not suffering any longer; invulnerability has almost been reached. Suffering belongs to the parents. The organisation towards invulnerability has been successful, and it is this that shows clinically along with regressive features that are not in fact essential to the picture.

Comment: Regressive features of defences are not essential, since they are primarily a form of self-support whereby the false self belatedly addresses needs that were not met in a timely manner by the environment.

> **Further reading:**
>
> Schizophrenia as a defence against vulnerability
>
> > 1971a, pp. 86-87
> > The diagnosis became changed during the consultation from one of relative (primary) defect to one of infantile schizophrenia, with the patient tending to make spontaneous recovery.
> >
> > It is interesting to note that schizophrenia, or the psychotic condition that resulted in a severe learning difficulty, is in fact a highly sophisticated defence organisation. The defence is against primitive, archaic ('unthinkable') anxiety produced by environmental failure in the stage of the child's near-absolute dependence. Without the defence there would be a breakdown of mental organisation of the order of disintegration, disorientation, de-personalisation, falling for ever, and loss of sense of real and of the capacity for relating to objects. In the defence the child isolates what there is of himself, and attains a position of invulnerability. In the extreme of this defence the child cannot be traumatised, and at the same time cannot be induced to rediscover dependence and vulnerability, and a return of liability to archaic anxiety […].

4. Further explanation of aetiology of schizophrenia: the idea of trauma in two phases

> Paragraph **AB**
> **(1)** It will be appreciated that this theory includes the idea of trauma, by which I mean an experience against which the ego defences were inadequate at the stage of emotional development of the individual at the time, or in the state of the patient at the time. **(2)** Trauma is an impingement from the environment and from the individual's reaction to the impingement that occurs prior to the individual's development of the mechanisms that make the unpredictable predictable.

Comment: (1) The defences mentioned here are not symptoms of pathology, since they are not organised against unthinkable anxieties. **(2)** Trauma unfolds in two phases, intrusion and reaction to intrusion. The second phase –reaction – does not in itself constitute a pathological defence organization and therefore should not be thought of as a schizophrenic illness. Winnicott returns in greater detail to the aetiology of schizophrenia in Paragraph **Q**. In the present context, the trauma in question corresponds to what he later designates ad type-A

trauma, briefly described in 1965a/1989, p. 145. For other types of traumas, see 1965a/1989, pp. 145-147. On the two phases of trauma, see also 1949/1958, pp. 182-183.

5. Additional explanation of two central elements of the theory of maturational trauma: failure and reaction, prior to the organization of defence mechanisms.

> Paragraph **AC**
> **(1)** Following traumatic experiences new defences are quickly organised, **(2)** but in the split-second before this can take place the individual has had the continuous line of his or her existence (as recorded in the personal computer) broken, broken by automatic reaction to the environmental failure.

Comment: (1) These new defences are what will constitute the illness. **(2)** Just as Humpty Dumpty shatters after a great fall, the individual's reaction to environmental failure is automatic and non-defensive, disrupting the patient's line of existence and, consequently, the unity of the nascent self. In his theory of maturational clinical practice, Winnicott suggests that it is more fruitful to attempt to restore the continuity of an infant's line of existence than to piece together the shattered pieces of Humpty Dumpty.

Further reading:

Specification of the reaction to external trauma at the beginning of the maturation process

> 1949/1958, pp.183-184
> **(1)** It may be pointed out that the most important thing is the trauma represented by the need to react. Reacting at this stage of human development means a temporary loss of identity. **(2)** This gives an extreme sense of insecurity, and lays the basis for an expectation of further examples of loss of continuity of self, and even a congenital (but not inherited) hopelessness in respect of the attainment of a personal life.

Comment: (1) Loss of identity is an alternative description of the breakdown in the establishment of the unit self and is the defining feature of schizophrenia and of a schizoid personality. **(2)** This loss gives rise to feelings of basic insecurity and lays the groundwork for psychotic paranoia and depression, another set of symptoms of the pre-I AM disorders.

6. Classification of unthinkable anxieties in terms of degree of disintegration

> Paragraph **AD**
> Elsewhere I have indicated the varieties of experience of 'unthinkable' or 'psychotic' anxiety. They can be classified in terms of the amount of integration that survives the disaster:

No integration retained	Disintegration
Some integration retained	Falling for ever Going off in all directions Somatic split; head & body Absence of orientation

	Loss of directed relating to objects
Integration retained	Unpredictable physical environment instead of 'average expectable'

Comment: This classification of unthinkable anxieties and their contents differs from the earlier ones (see Supplementary Readings 1 and 2 below) by using a new criterion: the amount of integration left after the traumatic event. This point is related to the emphasis placed in a text from the same year on integration as that which covers almost all developmental tasks (1967b/1986, p. 28). On the left-hand column, the anxieties are classified by decreasing degrees of loss of integration of the personality as a whole, resulting from reaction to environmental impingements, rather than according to the severity of the dissociation. On the right-hand column, the corresponding anxieties are classified according to their contents, that is to say according to the nature of trauma arising from the disturbance of integration: 1) return to a state of pathological non-integration (i.e., disintegration of the self); 2) a sense of endless falling the reflects disturbances in temporal integration; 3) a sense of dispersion or "going in all directions" that reflects disturbances in spatial integration; 4) loss of orientation, characterising disturbances in object relations linked to spatial disorganisation ; 5) absence of orientation involving the loss of directed relationships; 6) sudden and unpredictable intrusion of a current event, a form of external trauma that may generate unthinkable anxieties or, if less severe, hatred and paranoia (see 1965a/1989, p. 147).

Further readings:

1. A classification based on disturbances of normal maturation revealed in the content of unthinkable anxieties

> 1962d/1965, p. 58
> Unthinkable anxiety has only a few varieties, each being the clue to one aspect of normal growth.
> (1) Going to pieces.
> (2) Falling forever.
> (3) Having no relationship to the body.
> (4) Having no orientation.
> It will be recognized that these are specifically the stuff of the psychotic anxieties, and these belong, clinically, to schizophrenia, or to the emergence of a schizoid element hidden in an otherwise non psychotic personality.

Comment: This 1962 text – anticipating 1967 formulation – stresses that unthinkable anxieties signal disturbances in the accomplishment of the four main tasks of the early maturational process: the first theoretical feed, integration in

space and time, indwelling in the body, and object relating (on these four tasks, see 1962d/1965, pp. 59-60).

2. Another classification of unthinkable anxieties specifying the corresponding defences

> 1963c/1989, pp. 89-90
> From this chart [of the emotional growth] it is possible to make a list of primitive agonies (anxiety is not a strong enough word here).
> Here are a few:
> 1. A return to an unintegrated state. (Defence: disintegration.)
> 2.Falling for ever. (Defence: self-holding.)
> 3.Loss of psychosomatic collusion, failure of indwelling. (Defence: depersonalisation.)
> 4. Loss of sense of real. (Defence: exploitation of primary narcissism, etc.)
> 5. Loss of capacity to relate to objects. (Defence: autistic states, relating only to self-phenomena.)
> And so on.

Comment: Clinical material related to the five identified anxieties is detailed by Winnicott in a series of case studies, vignettes and clinical examples. The defences specified are essential pathological elements of schizophrenia and borderline disorders.

3. On active disintegration as a defence

> 1956/1958, pp. 304-305
> On the other hand, without the initial good enough environmental provision, this self that can afford to die never develops. The feeling of real is absent and if there is not too much chaos the ultimate feeling is of futility. The inherent difficulties of life cannot be reached, let alone the satisfactions. If there is not chaos, there appears a false self that hides the true self, that complies with demands, that reacts to stimuli, that rids itself of instinctual experiences by having them, but that IS only playing for time.

Comment: In this context, which is that of deep schizophrenia, defensive self-activity results in a state that of itself cannot go forward, "and in so far as disintegration must be maintained, so far must emotional development be in abeyance" (1988, p. 135). The maturational processed themselves are *actively desactivated*. As a consequence the patient does not mature, does get old, except somatically, nor can he or she afford to die, only just terminate. The false self comes to help.

7. Panic, as an example of a schizophrenic defensive organization

Paragraph **AE**

(1) The result of trauma must be some degree of distortion of development. It will be seen how normal and healthy anger would be in comparison with such awfulness. Anger would imply survival of the ego and a retention of the idea of an alternative experience in which the 'let-down' did not occur. **(2)** Clinically the state which is called 'panic' easily becomes a feature. Direct study of panic is unproductive because panic is itself a defence. It is of value to look on panic as an organised awfulness arranged around a phobic situation whose aim (in the defence organisation) is to protect the individual from new examples of the unpredictable. Good-enough mothering is that which enables a baby not to have to meet the unpredictable until able to allow for environmental failures.

Comment: (1) Healthy anger at trauma. **(2)** Panic as a defence which is triggered by anxiety arising from a reaction to disintegration, which -reveals a weakness in incipient integration and stands in contrasts to healthy anger in response to the same phenomenon.

Further reading:

Healthy anger

1971b, p. 29

Also, a baby under two years cannot be properly informed about the new baby that is expected, although "by twenty years or so" it becomes increasingly possible to explain this in words that a baby can understand.

When no understanding can be given, then when the mother is away to have a new baby she is dead from the point of view of the child. This is what dead means.

It is a matter of days or hours or minutes. Before the limit is reached the mother is still alive; after this limit has been overstepped she is dead. In between is a precious moment of anger, but this is quickly lost, or perhaps never experienced, always potential and carrying fear of violence.

Comment: The "precious" moment of anger in the infant is not a reaction to instinctual frustration, nor does it stem from some primitive destructive impulse, but is caused by a prolonged absence of the mother, experience as a loss of contact and a rupture in the continuity of communication with her (the "death" of the mother). These two conditions thwart the infant's innate tendency towards integration in early life (in this example, with the mother). Yet, even when persistent environmental failures hamper or impede the experience of anger, a healthy capacity for anger may remain. Thus, the quest for integration, even when interrupted at its inception, retains its urgency, which can now manifest itself in such a way that includes the fear of violence, either inflicted or suffered (in the case of paranoia). For an example of the lack of capacity for anger in a borderline patient, see 1962b/1965, p. 253.

VII. Aspects of maturational therapy for schizophrenia (Paragraphs AF to AH)

1. Consequences for the psychotherapy of schizophrenia

Paragraph **AF**
(1) An important corollary is one that affects all who engage in the psychotherapy of schizophrenia in patients of whatever age. **(2)** We give help by providing reliability which the patient can use in the sense that he or she can undo the defences that have been built up against unpredictability and the dire consequences in terms of the awfulness to be experienced.

Comment: (1) Winnicott speaks here of psychotherapy, not psychoanalysis. **(2)** The reason: the provision of *holding* in a reliable setting is not a psychoanalytic act, but a management function. Its purpose is to protect patients from the unpredictable and to enable them to confront the horrors of breakdown.

2. Provision of reliability

Paragraph **AG**
If we are successful we enable the patient *to abandon invulnerability and to become a sufferer.* If we succeed life becomes precarious to one who was beginning to know a kind of stability and a freedom from pain, even if this meant non-participation in life and perhaps mental defect.

Comment: The healthy people suffer more than those who are protected against vulnerability by withdrawal.

Further reading:

When the setting is most important

1955/1958, p. 297
(1) In the work I am describing the setting becomes more important than the interpretation. The emphasis is changed from the one to the other.

(2) The behaviour of the analyst, represented by what I have called the setting, by being good enough in the matter of adaptation to need, is gradually perceived by the patient as something that raises a hope that the true self may at last be able to take the risks involved in its starting to experience living.

Eventually the false self hands over to the analyst. This is a time of great dependence, and true risk, and the patient is naturally in a deeply regressed state. (By regression here I mean regression to dependence and to the early developmental processes.) This is also a highly painful state because the patient is aware, as the infant in the original situation is not aware, of the risks entailed. In some cases so much of the personality is involved that the patient must be in care at this stage. The processes are better studied, however, in those cases in which these matters are confined, more or less, to the time of the analytic sessions.

Comment: (1) A good example of Winnicott´s paradigm shift from talking-cure to care-cure. **(2)** The total behaviour not just the verbal behaviour of the therapist in the setting is the key for enabling the patient to restart the

recovery. **(3)** Description of what happens with the patient in regression with an observation on cases that require care outside the time and the space provided by the individual therapist (see the hospital treatment of M. Little).

3. Creation of personal conditions to abandon defences against vulnerability and to progress towards accepting life's predicaments

Paragraph **AH**
(1) At the start we seem to see clinical improvement, but as we proceed and the patient achieves dependence on us in a big way, *then our mistakes and failures become new traumata.* We learn to expect increasing sensitivity on the part of the patient, and we begin to wonder whether it is kindness or cruelty that motivates us. **(2)** We find that our inevitable specific and limited failures, often brought about by the patient, give opportunity for the patient to feel and express anger with us. Instead of cumulative trauma we get cumulative angry experiences in which the object (the therapist and his room) survive the patient's anger. No treatment of borderline cases can be free from suffering, both of patient and therapist.

Comment: (1) The analyst's inevitable failures introduce new external traumas. Is the therapist being kind or cruel? **(2)** Upon reflection, we find that when such failures are specific and tolerable, they provide an opportunity for the patient to express anger, which later may develop into hatred toward 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" (1962b/1965, p. 258) – and become the crucial operative factor in the process of recovery.

Further readings:

1. Facilitation of recovery is painful

1969a/1987, pp. 181-182
When they have become proficient in this and have come to trust their own belief in their basic identifications (with analysts) they can start meeting not the patient's instinctual desires but the patient's basic needs. In other words, they can start trying to treat borderline patients and a false-self organization where, as it were, a nursemaid brings the patient for analysis.

The analyst must be temperamentally suited for this kind of deeper work which is not always successful in terms of cure. If the patient feels that it is worth doing, it is worth doing, in spite of the fact that every stage which could be called an advance brings the patient into closer contact with pain. In other words, the patient gives up defences, and the pain is always there against which the defences were organized. This kind of work, as I have pointed out in talking about the treatment of psychotic children, could be described as cruel. When it succeeds, of course, the cruelty and the suffering are forgotten.

Comment: With adult schizophrenic patients in particular, the apparent "cruelty" of the Winnicottian therapy has an additional source: its ultimate

objective is to help the patient gradually to approach the original "indescribable" pain of being broken down, i.e., of going mad (1965b/1989, pp. 127-128).

2. A vignette: treatment felt to be cruel

> 1969c/1989, p. 118
> In this hour the patient referred to the previous hour in which I had given as an interpretation: "It is this non-scream that is in the way, that is to say the fear of not being heard or the hopelessness about screaming producing an effect." She said: "When you told me that I felt it was cruel. What is the use to say such a terrible thing to me?" I had joined it up with my failure in the transference, especially at the point of being unavailable when she arrived for the previous session. She now said: "It was really rather clever. It is not just a physical response to the scream that matters, you know, it is understanding. What you said felt awful. The fact was that *you* knew and *I* didn't and this is the only way that it is possible to correct the failure of my last scream to work."
>
> **Comment:** The understanding provided by the interpretation which exposes the patient to suffering is recognized by the patient as the only way to recovery.

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