Inéditos Loparic

Volume 2, Loparic Preprints – 2026

Elements of a Winnicottian Theory of Schizophrenia

Z. Loparic
IBPW/IWA

A (Tentative) Road Map for Studying Winnicott´s Psychology of Madness

Note: This working version of the map has two parts divided in topics, which name the contents of the paragraphs of Winnicott´s paper "The Psychology of Madness". Most of the paragraphs are followed by my short comments. The content of some of the paragraphs is expended in further readings. A tough revision of different aspects of the text as well of the structure and content of the Map is still needed.

Part I: A framework for reading the paper

I. Place of the paper "The Psychology of Madness" in Winnicott´s writings

A *Explorations,* p. 119

> **(1)** The practice of psychoanalysis for thirty-five years cannot but leave its mark. For me, there have come about changes in my theoretical formulation, and these I have tried to state as they consolidated themselves in my mind. **(2)** Often what I have discovered had been already discovered and even better stated, either by Freud himself or by other psychoanalysts or by poets and philosophers. **(3)** This does not deter me from continuing to write down (and to read when a public is available) what is my latest brainchild.

Comment. **(1)** This is a research paper, which summarizes thirty-five years of Winnicott´s theoretical research, with a special emphasis on theory of madness. This paper was left unpublished, which means that we have to take it with caution. Its content is closely related to chapters 18 (left unpublished) and 29 (this one published) of *Psychoanalytic Explorations,* which I suggest should be read together by those interested in staying this subject. **(2)** There are predecessors not only among psychoanalysts, but also among poets and philosophers, which stresses poetic (creative) and philosophical (reflexive) dimensions of Winnicott´s theory of madness (see the Preliminary Statement of "Fear of breakdown" **(3)** Persistence in doing research and presenting the results, with complaint about possible lack of interested public.

II. The main topic: theory of madness based on fear of madness

B *Explorations,* p. 119

> **(1)** At the moment I am caught up with the idea that psychoanalytic theory has something to offer in regard to the theory of madness, that is madness that is met with clinically either in the form of a fear of madness, or as some other kind of insane manifestation. **(2)** I would like to try to state this, even if I shall find that I am only stating the (psycho-analytically) obvious.
> **Comment**: **(1)** The statement of the main purpose of the paper: personal contribution to the theory of madness as it appears in the form of fear of madness or in symptoms of insanity. **(2)** Usual gesture of humility, rather displaced given the novelty of the content presented.

III. The paradigmatic framework: theory of maturation from absolute dependence to independence

C *Explorations,* p. 119

> We have the only really useful formulation that exists of the way the human being psychologically develops from an absolutely dependent immature being to a relatively independent mature adult. The theory is exceedingly complex and difficult to state succinctly, and we know there are great gaps in our understanding. Nevertheless, there is the theory, and in this way psychoanalysis has made a contribution which is accepted generally but usually not acknowledged.
> **Comment**. A very straightforward statement about his theory of maturational processes as guiding generalization of the study presented.

IV. On symptomatology

1. In the period of psycho-neurosis: every kind of symptom is normal, abnormality comes from the rigidity symptoms, not from the kind defences

D 119-120

> It was often said in reference to psychoanalytic theory that in the development of the normal child there is a period of psychoneurosis. A more correct statement would be that at the height of the Oedipus complex phase before the onset of the latency period there is to be expected every kind of symptom in transient form. In fact normality at this age can be described in terms of this symptomatology so that abnormality becomes related to the absence of some kind of symptom or to the canalisation of the symptomatology in one direction. It is the rigidity of the defences that constitutes abnormality at this phase, not the defences themselves. The defences themselves are not abnormal, and they are being organised by the individual along with his or her emergence from dependence towards independent existence based on a sense of identity. This comes to the fore in a new and significant way in adolescence.
> **Comment**. A statement about symptomatology and diagnosis of psychoneurosis, which differs very much from symptomatology and diagnosis of pre-I AM disorders, where symptoms are only few and do not reveal illness by being rigid.

2. Cultural influences on formation of symptoms

E 120

It is in this phase that the cultural provision as manifested in the child's immediate environment or in the family pattern alters the symptomatology although it does not of course produce the underlying drives and anxieties. What are referred to as symptoms in this context are not to be called symptoms in the description of a child because of the fact that the word symptom connotes pathology. Two side-issues from this theme can be mentioned. One that is so interesting is put forward by Erik Erikson, who shows that communities can mould what is being called here the symptomatology into directions which will eventually be valuable in the localised community,' The second has to do with the effect of a breakdown of the child's immediate environment at this stage so that in fact the child is not able to display the variegated symptomatology which is appropriate but must conform or take over an identification with some aspect of the environment, thereby losing personal experience.
Comment. A point on the theory of symptoms: cultural provision found in symptoms.

3. Neurotic because not psychotic

F *Explorations*, p. 120

(1) The theme of the polymorph-perverse symptomatology of childhood described by Paula Heimann - applies in this wide area of the manifestations that belong to the pre-latency period which would be called symptoms if they were to appear clinically when the individual has reached the age at which he or she would be expected to be adult. It can be understood how there came about the idea that in psychoanalytic theory all children were psychoneurotic, but on closer scrutiny we find that this is not part of the theory. **(2)** Nevertheless we are able to diagnose illness in children of this age which must be called psychoneurotic because it is not psychotic, and we find that the basis of our diagnosis is not observation of symptomatology but a carefully considered assessment of the defence organisation, especially its generalised or localised rigidity.
Comment. **(1)** The polymorph-perverse symptomatology of childhood described by Paula Heimann can be applied to the individual in pre-latency period if it were to appear he or she is she would be expected to be adult, not directly. And in that case, the point to make is about rigidity of defences. Somewhat restatement of Winnicott´s standard objection against transferring theory of neurotic illness to troubles of early infancy (see, for instance, Winnicott, 1962/1065, pp. 172 and 177).

V. Towards a maturational definition of psychosis

1. A new pathology: definition of psychosis in terms of maturational stages

G *Explorations*, pp. 120-121

(1) With the extension of psychoanalytic theory backwards and all the new work on ego psychology and on the stage of absolute dependence of infant on mother, etc., we have reached a new theme. We have reached to various theories which link psychoanalytic

> practice with the therapy of psychosis. By "psychosis" is meant in this context illness which has its point of origin in the stages of individual development prior to the establishment of an individual personality pattern. Obviously the ego support of the parental figures or figure is of the utmost importance at this very early stage which nevertheless can be described in terms of the individual infant unless there is distortion by

Comment. **(1)** Different extensions of the psychoanalytic theory to a kind of pathology revealed by what the traditional psychoanalysis calls “the wrong kind of case” (see Winnicott, 1962/1965, p. 169). **(2)** A maturational definition of psychosis which suggested to me a new Winnicottian name for it: “pre-I AM disorder”. **(3)** Immediate emphasis of the importance of the environment as aetiological factors.

2. Psychoanalytic aetiology of schizophrenia

H 121

> Psychoanalysis now comes to the consideration of the aetiology of illness which belongs to the territory of schizophrenia (be it noted that in this context it is necessary to jump back over the problems of the aetiology of the antisocial tendency and of depression, each of which needs separate treatment).

Comment. In the 1960s, theory of schizophrenia has more to do with schizophrenia than with antisocial tendency and of depression. That’s why the aetiology of schizophrenia is accordingly more relevant in the preset context. It is tempting to understand that Winnicott´s theory of madness belongs to the same territory. Yet, some caution in one place, as will be seen later on.

3. Critique of psychiatric aetiology of schizophrenia

I 121

> There is very great resistance, especially among psychiatrists who are not psychoanalytically oriented, to the idea of schizophrenia as psychological, that is to say at least theoretically capable of prevention or cure. In any case psychiatrists have their own problems. Every psychiatrist has an immense load of serious cases. He is always threatened by the possibility of suicide among the patients in his immediate care, and there are heavy burdens associated with taking responsibility for certification and decertification and with the prevention of such things as murder and the abuse of children. Moreover the psychiatrist must deal with social pressure since all those who need protection from themselves or who need to be isolated from society inevitably come under his care and in the end he cannot refuse them. He may refuse a case but this only means that someone else must take it. It can hardly be expected that psychiatry will welcome a study of the individual psychotic patient when such study seems to show that the aetiology of the illness is not entirely one of inheritance although inheritance and constitutional factors are often important.

Comment. Distancing from medical psychiatry which ignores environmental failures as aetiological external factors.

4. Winnicottian maturation aetiology of psychosis

1) Environmental aetiolgy of psychosis

J 121

> **(1)** The trend in psychoanalytic study of psychosis is nevertheless towards the theory of psychological origin. Surprisingly it appears that in the psychoses there is not only the inheritance factor but also an environmental factor operative at the very earliest stage, that is to say when dependence is absolute. **(2)** In other words the internal strains and stresses that belong to life and that are inherent in living and growing seem to be typically found in the normality that relates to psychoneurosis, psychoneurosis being evidence of failure. **(3)** By contrast, in digging down into the aetiology of the psychotic patient one comes to two types of external factor, heredity (which for the psychiatrist is an external thing) and environmental distortion at the phase of the individual's absolute dependence. **(4)** In other words psychosis has to do with distortions during the phase of the formation of the personality pattern, whereas psychoneurosis belongs to the difficulties that are experienced by individuals whose personality patterns can be taken for granted in the sense of being formed and healthy enough.
> **Comment**. (1) Application to the pre- I AM disorders in general of the thesis from 1949 that schizophrenia is “a sort of environmental deficiency disease” (Winnicott, 1948/1958, p. 162). **(2)** Traditional theory of psychoneurosis as resulting from internal factors is maintained, but is restated with the framework of Winnicott´s maturational pathology. **(3)** Explicit statement of two kinds of external factors. **(4)** Difference between “psychosis” and psychoneurosis stated in terms of theory of maturation.

2) Two kinds of experience of madness: one resulting from an occasional overstrain and the other from a patterned overstrain

K 122

> **(1)** The extremely complex theory or theories of very early infantile development lead the observing public to ask a question which is similar to the question: "Are all children neurotic?" The new question is: "Is every infant mad?" This is a question which cannot be answered in a few words, but the first reply must certainly be in the negative. **(2)** The theory does not involve the idea of a madness phase in infantile development. **(3)** Nevertheless the door must be left open for the formulation of a theory in which some experience of madness, whatever that may mean, is universal, and this means that it is impossible to think of a child who was so well cared for in earliest infancy that there was no occasion for overstrain of the personality as it is integrated at a given moment. **(4)** It must be conceded, however, that there are very roughly speaking two kinds of human being, those who do not carry around with them a significant experience of mental breakdown in earliest infancy and those who do carry around with them such an experience and who must therefore flee from it, flirt with it, fear it, and to some extent

be always preoccupied with the threat of it. It could be said, and with truth, that this is not fair.

Comment. **(1)** Parallel and distance to Freud. Switch from the language of schizophrenia to speaking about madness. **(2)** In Winnicott´s theory, not all children are mad. **(3)** Some experience of madness, resulting from overstrain at a given time of the personality structure resulting from the realizations of the tendency towards integration, 'which covers almost all developmental tasks" (Winnicott, 1967/1984, p. 28), must be theoretically allowed. **(4)** However, infants who do not receive good enough environment go through a significant experience of mental breakdown, carry it around all the lifelong and fear it. However, it may, he question be asked: is the mental breakdown and the same as madness and is the fear of it the fear of madness?

3) Madness in borderline cases and madness of total breakdown

L 122

(1) It is important to state this fact, that the psychoanalytic study of madness, whatever that means, is being done chiefly on the basis of the analysis of what are called borderline cases. **(2)** 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. **(3)** 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. **(4)** 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. **(5)** 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) Even though Winnicott does not define the concept of madness, he notes that at that time the psychoanalytic study of madness is based mainly on cases of borderline patients, which are also left without definition. **(2)** However, he also notes, the study of the patients pre-I AM[1] in terms of borderline troubles is not likely to be fruitful. **(3)** There remains the objection that the theory of madness in terms of borderline pathology cannot be used in understanding the madness which is revealed in the broken down case, *either* organized or not. Indeed, the breakdown has been defined in **K** as undoing of realizations of integration, not as organization of this undoing. **(4)** Winnicott concedes the validity of this objection, admitting that there are important differences between the two kinds of madness: the one revealed in borderline cases, namely, secondary defences against disintegration, and the other resulting

from cases of total breakdown – organized madness. As I will argue in the following, it is necessary to introduce the madness signalling the breakdown of the "continuous line of existence" (1968/2005, p. 155) as a septate category of pre-I AM maturational disorders, a thesis which Winnicott seems to embrace in the article commented upon[2], as well as in various clinical remarks scattered in his late writings. This interpretation allows to say: the breakdown of the line of existence does not generate borderline patients, but mad patients. Moreover, as will be seen, the treatment of the two kinds of madness is not the same. **(5)** Even though, the study and the treatment of the madness of disintegrated patients is still the best option for dealing with the madness of those who are the broken down[3].

Further readings

1. Fear of madness hidden in symptoms of hysteria

   Through Paediatrics, p. 100

   The analysis of the hysteric (popular term) is the analysis of the madness that is feared but which is not reached without the provision of a new example of infant care, better infant care in the analysis than was provided at the time of the patient's infancy. But, please note, the analysis does and must get to the madness, although the diagnosis remains neurosis, not psychosis.

   Comment. The popular term "hysteria' is here used to cover nearly the same ground as the psychoanalytic term "neurosis".

2. Connection between hysteria and the false self strategy of hiding the breakdown

   1963/1965, pp. 230-231

   […] especially does hysteria tend eventually to show psychotic features as analysis proceeds. And there is the very real bugbear of the as if personality – that I personally call the *False Self,* which presents well to the world, but our treatment must get behind it to the breakdown that is negated.

   Comment. Here Winnicott puts forward the idea that hysteria is the result of the false self strategy for hiding the psychotic breakdown under neurotic symptoms, psychotic breakdown related anxiety under neurotic ambivalence related anxiety and substituting neurotic defences for those used against psychotic anxieties.

3. Hysteria and madness in adolescence

1963/1965, p. 244

Illness during Adolescence
Naturally we find any and every disorder in this phase of development: Psycho-neurosisproper.
Hysteria, with some psychosis hidden away causing trouble but never showing up clearly as madness.

Comment. It would be worth discussing if at the bottom line there is such a pathology as psychoneuroses proper or this term is used by Winnicott here and elsewhere to state the following two phase methodological rule: first classify rigid symptoms related to ambivalence in the three body relationships as psychoneurosis, and next complete this diagnosis by saying that psychoneurosis notwithstanding being psychologically real may, in fact, be a product of the false self strategy, typical in borderline cases, used as a defence against a primitive agony. This rule provides a valuable help in avoiding futility in psychoneurotic analysis, that is the collusion of the analyst with psychoneurotic symptoms of the patient when in fact the illness is psychotic, and it all ends in destruction (Winnicott,1974/1989, p. 91). An even more intriguing question would be to ask if there is any Winnicottian maturational pathology of any stage which is not produced as a defence against agony revealing a breakdown due to the failure of child care in very early infancy.

4. Stuff of madness, that is of psychotic anxieties appearing in psychoneurotic transference

The Maturational…, 1963/1956, p. 220

In madness we find instead of repression the processes of personality establishment and self-differentiation in reverse. This is the stuff of madness and it is this which I am principally trying to describe. Failures in the maturational process (itself a matter of heredity) are of course often associated with pathological hereditary factors, but the point is that these failures are very much associated with failures of the facilitating environment. […] The basic assumption here is that the mental health of the individual is held down in the area of infant-care and child-care and both infant-and child-care reappear in the social worker's casework. In the psychotherapy of psycho-neurosis, which is essentially a disorder of inner conflict (that is to say, conflict within the intact integrated personalized and object-related self), these phenomena that derive from infant-and child-care turn up in that which is called the transference neurosis.

5. Case 1: Miss H, 50 years old

The patient has symptoms of a very severe neurosis, but in some circumstances her symptoms reveal that she is reliving the traumatic birth experience.

> Winnicott, 1948/1958, p. 180
>
> Hysterical patients make us feel that they are acting, but we know better than they can know that true affect is displayed and hidden in the hysterical manifestations.

6. Case 2: Woman 47 years old

a) Description 1

> Winnocott, 1949/1958, p. 249
>
> In the patient's previous analysis there had been incidents in which the patient had thrown herself off the couch in an hysterical way. These episodes had been interpreted along ordinary lines for hysterical phenomena of this kind. In the deeper regression of this new analysis light was thrown on the meaning of these falls. In the course of the two years of analysis with me the patient has repeatedly regressed to an early stage which was certainly prenatal. The birth process had to be relived, and eventually I recognized how this patient's unconscious need to relive the birth process underlay what had previously been an hysterical falling off the couch.

Comment. Here Winnicott´s diagnosis seems to be saying that the birth trauma is the external factor aetiologically related to the original breakdown of the patient's existence, not to the threat to her true self. This trauma may remain hidden under hysterical symptoms. This case also illustrates what Winnicott may have in mind in 1965 when he is speaking about the need to relive, not to remember the original breakdown or madness. The same case is discussed in

b) Description 2

> Winnicott, 1954/1958, pp. 179-280
>
> This case had originally presented itself as one in the first category of my classification [cases of interpersonal relationships, neuroses], but although the diagnosis of psychosis would never have been made by a psychiatrist, an analytical diagnosis needed to be made that took into account a very early development of a false self. For treatment to be effectual, there had to be a regression in search of the true self.

Comment. Here the diagnosis seems to change and says that what is affected is not the existence but the true self which by definition is based on the continuous line of existence and that it is defended by the false self by developing a neurotic variety of defence (hysteria). Under any interpretation, what is revealed in symptoms and defences is not in the inner conflict

(ambivalence), but either one or the other of two much earlier problems: that of losing the continuity of existing or that of not being able to exist as a unit self.

4) Aetiology of Madness in Early History

M 122-123

It seems unlikely that there is such a thing as madness which belongs entirely to the present. This way of looking at madness received an important reinforcement through the work on general paralysis of the insane. This illness is caused by a physical disease of the brain and yet it is possible to see in the psychology of the patient an illness which belongs specifically to that patient and his personality and character, and the details relate to the patient's early history. In the same way a brain tumour may produce a mental illness which will be like a mental illness which was latent in that individual but which would not have become manifest had it not been for the physical disease.

Comment. Madness is an illness of the patient's personality and character, and its origin is in the very early infancy. It is not said here which kind of illness, in particular if it is a disintegration, like the basic split in the environment-individual set-up or the sub-total split of the self. Physical illness may contribute to the manifestation of a latent personality illness

5) A case

N 123

Case: A boy in my care was brought to hospital because he was beginning to get bullied at school. He developed this tendency very steadily and gradually and it was this steady development that drew attention to the fact that there might be a physical cause for the illness. In a few months from the indefinite onset he became a person who provoked persecution and punishment. He was suffering from a sella tursica cyst, and as this increased in size, giving rise to intercranial pressure with papilloedema, he became a thorough going paranoid case. After the removal of the cyst he gradually returned to being like he was before the onset of the illness, quite free from a paranoid tendency. The cyst could not be entirely removed and after a few years there was a return of the illness along with a new growth of the cyst.

Comment. Maturation disorder such as paranoid tendency, which has remained latent can manifest itself as a comorbidity of a physical disorder, is here given as an example of what may happen with madness which is covered up.

V. Two previous contributions to the study of schizophrenia: relevance and limits

1. Ronald Laing's contribution

O 123

(1) At the present time Ronald Laing and his co-workers are drawing our attention to the way in which schizophrenia can be the normal state of an individual who is growing up or who has grown up in an environment that is dominated by persons with schizophrenic traits. **(2)** His clinical material is very convincing **(3)** but at the moment he fails to carry the logic of his attitude to a consideration of the same thing in terms of

the infant-parent relationship at the period of absolute or near-absolute dependence. **(3)** If he were to extend his work in this direction he would find what he is putting forward to be even more true and he would be getting near to making a significant statement in regard to. **(4)** In the meantime he is making significant observations about certain schizophrenic patients and already his work can be applied in the field of management-treatment of some mentally ill persons who are labelled schizophrenic.

Comment. **(1)** Laing points to the fact that schizophrenia can be the normal state of an individual in an environment that is dominated by persons with schizophrenic traits. **(2)** His point is convincing, yet **(3)** Laing ignores that a schizophrenic environment does not and can nor possibly meet the maturational needs of an absolutely dependent baby and that it impinges on his/her maturational process. **(3)** If Laing could accept this part of the theory of maturation he would come to a better diagnosis of schizophrenia, see it as disease – actually a product of a social illness – and could contribute significantly to the Winnicott´s thesis from 1948 on about the aetiology of schizophrenia. **(4)** Anyway, his reports on some schizophrenic patients and his clinical practice with them can be applied to management and treatment of persons that Winnicott "labels" as schizophrenic. For more on Winnicott´s stand on Laing's anti-psychiatry, see paragraph **AB** and comment.

2. One Winnicott´s initial attempt

P 123-124

(1) In my, paper "Psychosis and Child Care," which I gave in I952, I surprised myself by saying that schizophrenia is an environmental deficiency disease, i.e. it is an illness which depends more on certain environmental abnormalities than does psychoneurosis. It is true that there are also powerful inherited factors in some cases of schizophrenia, but it must be remembered that from the purely psychological angle inherited factors are environmental, that is, external to the life and experience of the individual psyche. **(2)** In this paper I was getting near to the statement about madness that I wish to make here and now.

Comment. **(1)** Wrong date, see above. **(2)** In the 1952 paper, madness is the primary madness of a healthy baby and has nothing to do with the breakdown from 1965. The basic split in the environment-individual set up stands nearer, but is still distant from the concept of disturbing integration.

Part II: Theory of the original state of breakdown

1. Critique of the axiom from 1964

R 124

(1) In my approach to my central but very simple theme I wish to bring in also the idea of the fear of madness. **(2)** This is something which dominates the life of many of our

patients. **(3)** I have written on this subject that it may be taken as an axiom that madness that is feared has already been experienced. In my opinion this statement contains an important truth and yet it is not quite true. A modification of the statement is needed, and this will take me to the heart of my communication.

Comment. **(1)** This statement substitutes the fear of madness for the fear of breakdown and. This is a significant development to be discussed in what follows of "Fear of breakdown", where the fear of breakdown is related to the reversal of the individual's maturational processes and schizophrenia not to madness, which is not mentioned at all. **(2)** The fear of madness is present in the lives of many patients. **(3)** This axiom – that is not a hypothesis, still less a statement of fact, but a statement of basic principles of Winnicott's theory of madness – was formulated after "Fear of Breakdown" (1963) and published in 1964 in his classical paper on classification of maturational diseases. One part of it is not true, the one in which says that the patient needs to remember the original breakdown ad that the memory can only come through re-experiencing. Also, it does not mention the

Further reading

The breakdown axiom from 1964

1959-64/1965, p. 139

(1) The breakdown that is feared has already been. **(2)** What is known as the patient's illness is a system of defences organized relative to this past breakdown. (**3)** Breakdown means a failure of defences, and the original breakdown ended when the new defences were organized which constitute the patient's illness pattern. **(4)** The patient can remember the breakdown only in the special circumstances of a therapeutic setting, and because of ego-growth.

(5) The patient's fear of breakdown has one of its roots in the patient's need to remember the original breakdown. **(6)** Memory can only come through re-experiencing. **(7)** Hence the positive use that can be made of a breakdown if its place in the patient's tendency towards self-cure be recognized and used practically.

(8) The original breakdown took place at a stage of dependence of the individual on parental or maternal ego-support. **(9)** For this reason work is often done in therapeutics on a later version of the breakdown – say a breakdown in the latency period, or even in early adolescence; this later version occurred when the patient had developed ego-autonomy and a capacity to be a person-having-an-illness. Behind such a breakdown there is always, however, a failure of defences belonging to the individual's infancy or very early childhood.

Comment. **(1)** The 1964 Axiom is about the original breakdown the first and the worse disaster that may take place in human life. has already been as is feared as coming in the future. **(2)** Diagnosis of breakdown is made based on defence organizations. **(3)** Sequence of what has happened: impingement by external factors, failure of original defences, original breakdown immediately ended by new defence organizations (in the following: "organized madness").

(4) The breakdown can be remembered in the therapeutic setting and due to the newly developed strength of ego. **(5)** There is a need to remember, it is not said how. **(6)** The answer: to be remembered the breakdown has to be re-experienced. **(7)** There is a connection of remembering and the tendency towards self-cure. **(8)** Connection between breakdown and dependence on parents. **(9)** Later versions of the breakdown, behind all of which there is a failure of defences in very early stages.

2. Symptoms of the fear of madness

S 124

(1) To continue with the theme in these terms, a significantly large number of persons, some of whom come into analysis or into psychiatric care, live in a state of fear which can be tracked down to a fear of madness. **(2)** It may take the form of a fear of incontinence or a fear of screaming in public, or there may be panics and the fear of panics which is even worse; and there may be a sense of impending doom and various other very severe fears each of which contains an element which is outside the operation of logic. **(3)** A patient may, for instance, be dominated by a fear of dying which has nothing to do with the fear of death but which is entirely a matter of the fear of dying without anybody being there at the time; i.e. with nobody there who is concerned in some way that derives directly from the very early infant-parent relationship. Such patients can organise life so that they are never alone.

Comment. **(1)** Shift from fear of breakdown to fear of madness. Frequent state of fear of madness is signalled by the pre-I AM paranoia kind of symptom, which is present in life of many persons and may show up in treatment. Here the fear of breakdown revealed by symptoms as fear of madness, not, as in "Fear of breakdown", to the phenomena which belong to the reversal of the maturational processes **(2)** Examples of common symptoms of fear of madness arising outside of treatment. On panic as related to a schizophrenic anxiety, see below, paragraph **Y** and Winnicott, 1968/1968, p. 199. **(3)** Fear of death may be a defence against fear of breakdown, 1874/1989, p. 92). Fear of dying is related to the lack of capacity to be alone. A further example is given in paragraph **U**. It should be noted that these symptoms are not the same as those present in the content of psychotic anxieties (see below paragraph **Y**, and Winnicott, 1974/1989, pp. 89-90), which result in defences of schizophrenic kind. This suggests that there is more research to be done in specifying this group of pre-I SM symptoms and of the breakdown of the maturation processes which lies beneath them. This specific group of symptoms, together with the diagnosis of breakdown that they allow to build, and corresponding treatment procedures may be seen constituting a chapter on its own right in Winnicott´s theory of pre-I AM disorders.

3. Futility of standard analysis of fear of madness

T 124-125

> **(1)** In trying to receive the communication that these patients attempt to make when we give them a chance, as we do especially in psychoanalysis, what we find looks like a fear of madness that will come. It is of value to us if not actually to the patient to know that the fear is not of madness to come but of madness that has already been experienced. It is a fear of the return of madness. **(2)** One might expect that an interpretation along these lines would relieve the situation, **(3)** but in fact it is unlikely to produce relief except in so far as the patient gets relief from intellectual understanding of what is likely to turn up in the course of further analysis. **(4)** The reason why relief is not obtained by the patient is that the patient has a stake in remembering the madness which has been experienced. **(5)** In fact a great deal of time can be spent in remembering and reliving examples of madness which are like cover memories. **(6)** The patient's need is to remember the original madness, but in fact the madness belongs to a very early stage before the organisation in the ego of those intellectual processes which can abstract experiences that have been catalogued and can present them for use in terms of conscious memory. **(7)** In other words madness that has to be remembered can only be remembered in the reliving of it. **(8)** Naturally there are very great difficulties when a patient attempts to relive madness, and one of the big difficulties is to find an analyst who will understand what is taking place. It is quite difficult in the present state of our knowledge for the analyst to remember in this kind of experience that it is the aim of the patient to reach to the madness, i.e. to be mad in the analytic setting, the nearest that the patient can ever do to remembering. **(9)** In order to organise the setting for this the patient sometimes has to be mad in a more superficial way, i.e. has to organise what Dr Little calls a delusional transference, and the analyst has to take the delusional transference, accept it and understand its performance.

Comment. **(1)** This is a statement of the main thesis of the paper: fear of the madness to come is fear of the return of madness. **(2)** In the traditional theoretical context, it could be supposed that the problem can be treated by interpretation of verbalized memories of madness, but **(3)** that is not the case, except in so far as it favours patient's mentally processing, that is to say his thinking about what will come next in analysis. **(4)** The reason why interpretation does not work is that the patient has interest in trying to make the madness *conceivable*, but in fact he needs to remember the original madness which has been and which he thinks wrongly has been *experienced*. **(5)** However, he may spend a lot of time in analysis in remembering cover memories, which are defences against original madness. **(6)** In fact, the original madness has not been experienced since it happened very early and at that time he did not have intellectual equipment, in particular the capacity of abstraction, to frame what was going on in such a way that it can be brought to conscious memory by verbalization, which is a clear indication of the limits of the power of verbalization and interpretation in curing the fear of madness. **(7)** Remembering original madness can only be achieved by reliving it in the present time, either by becoming mad temporarily in the setting or in a mental hospital (see Winnicott, 1974/1989,

p. 92). **(8)** Here the patient's difficulty is to find a therapist who has a sufficient theoretical training to understand his need to be mad in the setting, to reproduce in a local and less severe way the patient's breakdown and to support the burden of his need transmitted in psychotic transference for absolutes and unconditional dependence. **(8)** A more superficial solution consists in the patient producing not localized madness but Little's delusional transference and the therapist acting adequately in meeting it.

4. A vignette exemplifying madness showing up in the analytic setting

U 125

> For example, **(1)** a girl who is at school brings to the analysis the idea of being given too much homework and being over-pressed at school. She brings this as very urgent material and **(2)** it helps her to get to an extreme of agony with a severe headache and hours of screaming. **(3)** She has been able to tell me that in fact her teacher is not over-pressing her and also that she has not been given too much homework. It is not even possible for me in making interpretations to talk about the idea of a strict teacher who overtaxes her pupil. **(4)** In terms of the teacher and the homework the patient is telling me that I am overtaxing her and any word from me, even a correct interpretation, is a persecution. **(5)** The point of the exercise is that without being too mad in the secondary sense this patient is able then to reach to the re-experiencing of the original madness, or at any rate she gets to an extreme of agony which is next door to the original madness.

Comment. **(1)** Very urgent verbal complaint of the patient for over-pressing at school, which **(2)** as Winnicott´s understands, helps her to produce body symptoms (headache and long incontinent screaming) which reveal an extreme agony (see paragraph **S**). **(3)** The patient is able to see that her complaints about school are not true, but she does allow Winnicott´s use of interpretation of her complaint. **(4)** Her complaints are, in fact, a refusal of Winnicott´s use interpretation to help her. To her any word of his is no better than persecution of the teacher, in other words, it is a mistake resulting in a new trauma. **(5)** By tolerating this kind of tension, which he does, Winnicott gives her opportunity to produce exercises in *secondary madness* which gets her as near as she possible to the *original madness*. In this case, the treatment does not consist in bringing her to reason, but in allowing her to be locally mad in the setting. This vignette exemplifies one main feature of the treatment of the fear of madness, which is discussed in paragraph **AB** below.

5. Urge to be normal and urge to get to madness

V 126

> **(1)** In such a case any attempt on the part of the analyst to be sane or logical destroys the only route that the patient can forge back to the madness which needs to be recovered in experience because it cannot be recovered in memory. In this way the analyst has to be able to tolerate whole sessions or even periods of analysis in which logic is not

applicable in any description of the transference. **(2)** The patient then is under a compulsion, arising out of some *basic urge that patients have towards becoming normal,* to get to the madness; and this is slightly more powerful than the need to get away from it. **(3)** For this reason there is no natural outcome apart from treatment. The individual is forever caught up in a conflict, nicely balanced between the fear of madness and the need to be mad. **(4)** In some cases it is a relief when the tragic thing happens and the patient goes mad, because if a natural recovery is allowed for, the patient has to some extent "remembered" the original madness. This is, however, never quite true, but it may be true enough so that clinical relief is obtained by the fact of the breakdown. **(5)** It will be seen that if in such a case the breakdown is met by a psychiatric urge to cure then the whole point of the breakdown is lost because in breaking down the patient had a positive aim and the breakdown is not so much an illness as a first step towards health.

Comment. **(1)** For recovery is needed regression, which, in this context, means experiencing the original madness in a not too mad way. **(2)** The patient is a conflict between two opposite urges: becoming normal and becoming locally mad. **(3)** In general, no self-cure is possible apart from the treatment mediating the “conflict”, which, it must be noted, is not an inner psychic one. **(4)** In some cases, however, a tragic maddening event resulting in an actual breakdown of the patient may help to reach to the original madness and bring some relief. **(5)** This kind of breakdown should not be submitted to psychiatric treatment but *understood* as a first step towards health (see paragraph **AC**)

Further reading

The case of the woman who dreamed about a tortoise: split between the urge to live and the urge to die

W1 Winnicott, 1963/1965, p. 250

By killing herself she would gain control over being annihilated while dependent and vulnerable. In her healthy self and body, with all her strong urge to live, she has carried all her life the memory of having at some time had a total urge to die […].

5. Adaptation of a basic principle traditional psychoanalysis

W2 126

(1) At this point it is necessary to remember the basic assumption that belongs to the psychoanalytic theory that defences are organised around anxiety. What we see clinically when we meet an ill person is the organisation of defences and we know that we cannot cure our patient by the analysis of defences although much of our work is engaged in precisely doing this. **(2)** The cure only comes if the patient can reach to the anxiety around which the defences were organised. **(3)** There may be many subsequent versions of this, and the patient reaches one after another, but **(4)** cure only comes if the patient reaches to the original state of breakdown.

Comment. **(1)** A basic principle of treatment: reaching to the anxiety beneath defence organizations. Now in Winnicott, there are two basic kinds of anxiety: psycho-neurotic and pre-

I AM (psychotic). The later may be better described as agonies. **(2)** Reaching to the anxiety is a necessary for cure. **(3)** Reaching to the anxiety is not a sufficient condition of cure: it is also necessary to reach to the disturbance of the maturational processes revealed by the successive versions of the anxiety. **(4)** This point particularly relevant to the treatment of the fear of madness: reaching to the pre-I AM agony related to the breakdown is not enough: it is needed to relieve the original breakdown in small doses (see the paragraph **AB**). This point may be read as introducing the distinction between reaching to the maturational disorder of the collapsed patients and getting back through the staged of the schizophrenic reversal of the individual's maturational process.

6. Madness taken in the common and in technical meaning

X 126-127

> **(1)** It is now necessary to try to state what is wrong with the wording of the axiom that the fear of madness is the fear of madness that has been experienced. **(2)** First it is necessary to be quite clear on one point, which is that the words "the fear of madness" ordinarily would refer to the fear that anyone might have or should have at the thought of insanity; not only the horror of the illness itself with all the mental pain involved, but also the social effect on the individual and even on the family of the fact of mental breakdown, which the community fears and therefore hates. **(3)** This is the obvious meaning of the words that are being employed here, and it is necessary to point out that in this particular study the words are being used differently. **(4)** These same words are being used to describe what we may discover about unconscious motivation in patients who have been in analysis for a long time, or who have become by some means or other, perhaps through the passage of time and the process of growth, able to tolerate and cope with anxieties which were unthinkable in their original setting.

Comment. (1) Introduction to the revision of the breakdown axiom, formulated in paragraphs **Y**, **Z** and **AA**. **(2)** Ordinary meaning of the terms "madness" and "fear of madness". **(3)** A technical meaning of the word madness comes from Winnicott´s theory of maturational processes: "madness" refers to disturbances of the achievements in the stage of the theoretical first feed consisting in *degrees of disintegration* (see paragraph **Y** below and Winnicott, 196/1989, p. 198), which are signalled by psychotic, that is schizophrenic anxieties. These anxieties have been unthinkable, which means intolerably painful and unbelievable[4], but have become thinkable in the therapeutic setting and cure was obtained by tolerating and coping such anxieties.

[4] In common usage, "unthinkable" means so emotionally shocking, that what has happened but cannot be imagined as possible.

Further readings

1. An example of personality disintegration and respective unthinkable anxiety

1969/1989. p. 115

Roughly the statement is that the chronic skin irritation or discomfort emphasises the limiting membrane of the body and therefore of the personality and behind this is the threat of depersonalisation and a loss of body boundaries and of the unthinkable almost physical anxiety which belongs to the reverse process of that which is called integration.
One example of this unthinkable anxiety is the state in which there is no frame to the picture; nothing to contain the interweaving of forces in the inner psychic reality, and in practical terms no-one to hold the baby.

Comment. **(1)** Definition of a physically determined depersonalization process (loss of the psycho-somatic collusion) which is the reverse of the integration process and makes out the content of an unthinkable anxiety. **(2)** Two descriptions of such an anxiety: 1) the metaphorical one: no frame to the picture, and 2) an existential one: no arms to hold the baby's body.

7. Getting near to the breakdown of original defences

Y128-128

(1) Secondly, there is something wrong with the statement even in the specialised setting in which it is being given in this chapter. **(2)** It is not really true to say that the patient is trying to remember madness which has been and around which defences were organised. **(2)** The reason why this is so is that at the original place where the defences were organised madness was not experienced because by the nature of what is being discussed the individual was not able to experience it. A state of affairs arose involving a breakdown of defences, defences that were appropriate at the age and in the setting of the individual. The ego support of a parental figure has to be taken into consideration here in regard to its being a reliable or unreliable support. **(3)** In the simplest possible case there was therefore a split second in which the threat of madness was experienced, but anxiety at this level is unthinkable. Its intensity is beyond description and new defences are organised immediately so that in fact madness was not experienced. **(4)** Yet on the other hand madness was potentially a fact. **(5)** In attempting to find an analogy I saw a hyacinth bulb being planted in a bowl. I thought, there is a wonderful smell locked up in that bulb; I knew of course that there is no place in the bulb where a smell is locked up. Dissection of the bulb would not give the dissector the experience of a smell of hyacinths, if the appropriate spot were to be reached. Nevertheless there is in the bulb a potential which eventually will become the characteristic smell as the flower opens. **(6)** This is only an analogy but it could carry a picture of what I am trying to state. It is an important part of my thesis that the original madness or breakdown of defences if it were to be experienced would be indescribably painful. **(7)** The nearest that we can get is to take what is available of psychotic anxiety such as a. disintegration, b. unreality feelings, c. lack of relatedness, d. depersonalisation or lack of psychosomatic cohesion, e. split-off intellectual functioning, g. E.C.T. with panic as a generalised feeling which may contain any of these.

Comment. (1) Theory of psychotic unthinkable anxieties getting tolerable in the setting is not good enough for the understanding of the anxiety corresponding to the threat of madness. **(2)** One important change in the original version of the axiom in fact, the patient is not trying to remember the madness. **(3)** The reason: the patient, suffering a breakdown, is by definition not able to experience the resulting state of madness; thus, for him, the madness is not a fact to be remembered. **(4).** Theoretical sequence of what happened: a) defences of whatever there is to be defended (see below) against impingements by external factors were broken, b) there was a split second in which the threat of madness was experienced, c) in such a situation the level anxiety is unthinkable, d) the intensity of the anxiety at this level, that is to say, of the pain of becoming mad cannot be just said to be shocking, it cannot possibly be described at all nor brought to awareness, e) new defences preventing the indescribable anxiety to experienced have immediately been organized so that in fact the anxiety nor the madness was experienced. **(4)** Yet, the madness and the corresponding breakdown of the line of existence was potentially a fact of experience. **(5)** To explain this statement which is difficult clinically and philosophically Winnicott gives an analogy: there is a hyacinth bulb in a protecting environment, there is a wonderful smell locked in it, but there is no place for that smell, so the smell cannot be found by dissecting the bulb; therefore it cannot be an established fact, yet there is in the bulb a potential, something which under circumstances can be experienced as a characteristic smell. **(6)** My interpretation of the analogy: a) original madness and madness is like the characteristic smell, b) the hypothesis that it was experienced cannot be described. **(7)** The nearest that the patient can get to the madness is to reach to the content which is made available in the experience of psychotic anxieties the content of which is not the original breakdown of the continuous line of the individual's existence, but the deactivations of the later achievements in the stage of the theoretical first feed.

Further readings

1968/1989, p. 198

(1) 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:

disintegration,

falling forever. going off in all directions,

somatic split; head & body,

absence of orientation,

loss of directed relating to objects,

unpredictable physical environment instead of "average expectable".

Comment. **(1)** The "unthinkable" or "psychotic" anxieties are experienced. This experience is very painful and requires defences by which the schizophrenic pre-I AM disorders, schizophrenic kind of madness, are defined. **(2)** Their content is not the breakdown of existence, but the degrees of damage caused by the double phased trauma (impingement and reaction to it) to the realizations of the tendency towards integration, starting with the main three ones: integration in space and time, indwelling in the body and relating to objects, which have already been mentioned in the paragraph **Y** above.

7. Difference between experiencing psychotic anxiety and reliving the original madness

Z 128

(1) Nevertheless we can see if we look that whenever we reach to any of these things [psychotic anxieties] clinically we know there is some ego-organisation able to suffer, which means to go on suffering so as to be aware of suffering. **(2)** The core of madness has to be taken to be something so much worse because of the fact that it cannot be experienced by the individual who by definition has not the ego-organisation to hold it and so to experience it.

Comment. (1) Reaching to the contents of psychotic anxieties implies the existence of some remnants of "ego-organization" which make it possible for the individual to suffer and to be aware of suffering as regards disturbance of some aspects of the normal development during the first theoretical feed. These contents are not at the core of madness. **(2)** The core of madness is a state that cannot be experienced because of nonexistence or the destruction of the conditions of possibility of any kind of experience, like successful integration in time and space.

8. An explanation of the state of affairs X

AA 128

(1) It might be valuable to use a symbol, X, and so say that the infant or small child **(2)** has an ego-organisation appropriate to the stage of development and that something happens such as a reaction to an impingement (an external factor which has been allowed through by faulty environmental functioning) and that then there is a state of affairs called X. **(3)** This state may result in a re-organisation of defences. **(4)** Such may happen once or many times or perhaps many times in a pattern. **(5)** From the organisation of the defences one gets a clinical picture and the diagnosis is made on the basis of the defence organisation. **(6)** The defence organisation in turn depends for its characteristics to some extent on a contribution from the environment. What is absolutely personal to the individual is X.

Comment. **(1)** Significant widening of the period in which madness may arise, which requires a renewed study of aetiology and of aspects of the maturational processes affected. **(2)** The theoretical sequence of happenings with a baby of small child: a) there is an acquired ego-organization protecting the maturational processes and their achievements, b) there a traumatic environmental failure impinging, c) the happened the reaction to the impingement, d) then there is "state of affairs" called X, an unknown, both to the patient and to the therapist. **(3)** In defence against the repetition of it are raised secondary defences. **(4)** Timing and pattern of these defences is variable. **(5)** These defences are used for diagnosis of the kind and of the degree of the damage suffered. **(6)** Defences are produced by using preserved or newly acquired capacities and contributions from the environment, which may include it seems defences against of the borderline kind. As it is easily seen, only the structure of what is happening is described, scarcely the content. In particular, the concepts of the state of affairs X and of defences against it are void. It can nevertheless be assumed that X is the state of the original breakdown, resulting in fear of madness

Further readings

1. The basic meaning of the breakdown

Winnicott, 1968/1989, p. 198

(1) […] by [trauma] 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. 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.

(2) Following traumatic experiences new defences are quickly organised, (3) 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. This passage come from an article written in 1967 and *published* by him in 1968, which gives it full authority. I understand that it can be seen as bringing developments and corrections of the previous two unpublished papers. **(1)** Maturational definition of trauma in the very early stages. **(2)** Statement on the quickly organized new defence without details about their nature. **(3)** Statement on the damage done by the reaction to impingement: the breakdown of the continuity of existing, Frenchified term for being. If I am right, here we find the theoretical explanation of the stuff of the state of affairs called X. It follows that the problems of the establishment of the unit self and those of the first theoretical feed are not part of it. However, precisely these problems are revealed in the content of schizophrenic (psychotic) anxieties and in symptoms which belong to borderline cases (see Further Reading to the paragraph **Y**.

2. Breakdown defined in terms of interruption of existence

1963/1965, p. 86

(1) I am still talking about absolute dependence. It is all a matter of impingement, or no impingement, on the infant's existence, and I want to develop this theme.

(2) All the processes of a live infant constitute a *going-on-bein*g, a kind of blueprint for existentialism. **(3)** The mother who is able to give herself over, for a limited spell, to this her natural task, is able to protect her infant's going-on-being. **(4)** Any impingement, or failure of adaptation, causes a reaction in the infant, and the reaction breaks up the going-on-being. **(5)** If reacting to impingements is the pattern of an infant's life, then there is a serious interference with the natural tendency that exists in the infant to become an integrated unit, able to continue to have a self with a past, present, and future.

Comment. **(1)** This I understand is the basic thesis about the nature of the original breakdown. **(2)** Very significant connection to philosophy. **(3)** Protecting the going-on-being, clearly a dimension of human individuals treated typically by philosophers (Heidegger, for instance). **(4)** Impingements result in a reaction which breaks up the continuity of being, not the structure of the personality. **(5)** This reaction may become a pattern of life and then various maturations achievements which belong to the personality structure are interfered with, in the first place, as said, those of the establishment of the unit self and of the theoretical first feed.

9. Restatement of the breakdown axiom, applied to the treatment of collapsed mad patients

AB 129

(1) I now come to an attempt to restate the original axiom. **(2)** The individual who reaches these things in the course of a treatment is repeatedly reaching towards X, but of course the individual can only get as near X as the new ego strength plus ego support in the transference can make possible. **(3)** The continuation of the analysis means that the patient continually reaches to new experiences in the direction towards X and in the way I have described these experiences cannot be recalled as memories. They have to be lived in the transference relationship and they appear clinically as localised madnesses. **(4)** Constantly the analyst is bewildered by finding that the patient is able to be more and more mad for a few minutes or for an hour in the treatment setting, and sometimes the madness spreads out over the edges of the session. **(5)** It requires a considerable experience and courage to know where one is in the circumstances and to see the value to the patient when the patient reaches nearer and nearer to the X which belongs to that individual patient. Nevertheless if the analyst is not able to look at it in this way, but out of fear or out of ignorance or out of the inconvenience of having so ill a patient on his hands he tends to waste these things that happen in the treatment, he cannot cure the patient. **(6)** Constantly he finds himself correcting the delusional transference or in some way or other bringing the patient round to sanity instead of

> allowing the madness to become a manageable experience from which the patient can make spontaneous recovery. **(7)** Looked at in this way psychiatry that is based on meeting social need and the treatment of large numbers of patients is at the present time in a phase of fighting the wrong enemy. **(8)** This is brought out in the work of Ronald Laing and his collaborators. It does not matter if we find that we cannot always agree with their theory or with their presentation of their theory. At any rate my thesis in this paper compels me to welcome many of the statements of these workers in the field.

Comment. **(1)** Restatement of the breakdown axiom and description of its application in treatment. **(2)** These are the conditions of possibility for getting near to it by working through successive the states of madness. **(3)** Experiences obtained in the treatment are not memories. **(4)** They are experiences of actual madness localized in time and space. An example of what may profitably happen in treatment is given in the paragraph **U**. **(5)** Requirements for the therapist. **(6)** The main objective is not bringing the patient to reason but managing of localized manifestations of madness as a starting point of recovering a spontaneous self, able to seek recovery in a creative manner. **(7)** Official psychiatry is on the wrong track when it attacks defence organizations of mad patients, instead managing them. **(8)** Despite of theoretical objections to Laing's theory of schizophrenia (see paragraph **O**), his anti-psychiatry must be welcomed.

Further reading

A parallel with the treatment of borderline cases

1964/1988b (*Babies*…), pp. 44-45

> **(1)** In the so-called "borderline" case there is a drive towards progress in the emotional development that has been held up. There is no way of remembering very early experiences except by a reexperiencing of them, and **(2)** as these experiences were excessively painful at the time, because they came when the ego was unorganised and the auxiliary ego of the mothering was faulty, **(3)** the reexperiencing has to be done in a carefully prepared and tested situation, such as the setting provided by the psychoanalyst. **(4)** Moreover, the analyst is there in person, so that when all goes well, the patient has someone to hate for the original failure of the facilitating environment which distorted the maturational processes.

Comment. **(1)** Here, remembering is still understood as reexperiencing. It may be understood that Winnicott is talking about reexperiencing maturations disturbances signalled by psychotic anxieties. **(2)** These experiences were excessively painful, because ego is unorganised and there I no sufficient external support. **(3)** Nevertheless, the reexperiencing can take place in an adequate professional setting. **(4)** Moreover, the analyst, especially as fails and makes mistakes, can be hated. And if he or she survives, the analyst can be brought under control, which though limited to the transference situation helps the patient

to recover from the loss of omnipotent control in the original mother environment. In all four point, this description of reaching to madness and of the treatment of madness of the borderline cases differs from the treatment of the madness as explained by Winnicott in the paragraph **AB**.

10. Limits of the applicability of the new breakdown axiom in psychotherapy

AC 129

(1) It is unfortunate that the theory that I am putting forward here, even if it is correct, certainly does not lead to an immediate step forward in affecting psychotherapy. **(2)** It will not be found by those who are meeting these problems in their psychoanalytic practices that this detail of theory makes it possible for them to do better work tomorrow. In fact at its best it can give them some understanding and of course it may lead them into deeper waters. **(3)** Nevertheless there are some cases where the patient goes on trying to get help from us and yet we cannot reach a satisfactory endpoint, and of course these cases are of various kinds; one kind I am suggesting can be understood better on the basis of the thesis that I am putting forward, and an advantage here is that if the analyst understands what is going on he or she is able to tolerate the very considerable tensions that belong to this kind of work. **(4)** Unfortunately there is only one way of avoiding these tensions and that is by better diagnosis to avoid taking on the kind of case that must inevitably lead into these deep waters. Then if we do find a method by which we may avoid taking on these cases we must be honest and admit out loud that we need even in our theory the psychiatric help which in some ways we despise because it is not based on psychology, i.e. the physical treatments. **(5)** It has occurred to me, perhaps wrongly, that from a general acceptance of this idea that I am promulgating when it arrives in the literature that is read by the thinking public, there could come some relief from the idea. It is impossible to predict but it seems to me that there is a great deal of fear of breakdown, and if it could seep through that the breakdown that is feared is a breakdown that has already done its worst, there is at least the possibility that the edge of the fear of breakdown could be dulled.

Comment. **(1)** The psychotherapy of patients with breakdown, call it psychoanalysis or not, is not immediately benefited by Winnicott´s theory of madness in terms of defence organization against breakdown which takes place in early life of babies and children. **(2)** At best it gives some help in understanding patients who have had such a beginning of life. **(3)** This may help the therapist to be able to better tolerate tensions created in the setting by mad patients. **(4)** It may be necessary to ask for help outside the area of psychology of madness, in physical psychiatry. **(5)** Be it as it may, understanding madness in Winnicott´s terms may diminish the devastation coming from the fear of the breakdown of the line of existence.

References

Winicott, (1952). Anxiety Associated with insecurity, *Da pedatria* …