I cannot assume, of course, that the way in which my ideas have developed has been followed by others, but I should like to point out that there has been a sequence, and the order that there may be in the sequence belongs to the evolution of my work.

(D. W. Winnicott, 1968b, p. 86)

The development of Winnicott's thinking over the course of his career, reflected in his extensive oeuvre, demonstrates an extraordinary internal coherence. In this paper I will focus my remarks on only what I have defined as “the clinical Winnicott”. By this I mean those aspects or areas of Winnicott's thinking that permit us to consider his specifically clinical contribution usually neglected and not sufficiently valued with respect to the Winnicott who produced enormous contributions to the psychoanalytic theory of development (Abram, 1996) or to the Winnicott who is considered only in the light of his monumental and highly influential theory of transitional space.

My conviction, in contrast to the emphasis in the literature, is that Winnicott's clinical thinking and practice form the basis upon which the author constructed his theory of infant development in relation to the environment, as well as his important contributions on the birth and development of the self and on the transitional area. The concept of transitional space is revolutionary not only because it broadens the scope of clinical psychoanalysis, but also because Winnicott “invented” it with the aim of locating those objects that, in the theory of his time, did not exist because there was no space into which to position them or to see them. These objects are what Winnicott sees and interprets, but other analysts, not equipped with his theory, cannot gain access to them (Bollas, 2007).

In focusing on the clinical Winnicott I will be referring here to what I consider a sort of generative core in Winnicott's ideas, a crucial “object” in his clinical thinking that may even have been unknown to the author himself, which has been disentangled and has become understandable only later.

We can consider his 1945 paper, “Primitive emotional development” as a sort of implicit “master plan” from which clinical thought departs and is developed (an issue first addressed by Ogden, 2001).

Toward the end of his work - as shown in the epigraph - Winnicott became aware of his own participation in the origin of the so-called British Independent Group (Kohon 1992; Giannakuolas, 2010), which formed a strong current in the flow of British psychoanalysis. This school of thought had taken the best of the extraordinary Kleinian revolution of the 1940s,
but had then placed the patient in the foreground, emphasizing his intrapsychic needs and his self-state.

In a little note that appears to have been just “thrown down,” so to speak, on the first page of chapter 3 of *Human Nature* (1988), Winnicott - jotting down an idea to be developed, almost like a hermetic verse of a Montale poem - writes, “*Note for revision:* psychoanalysis starts with the patient + → develop theme to unconscious cooperation process, growth and use of intimacy, self-revelation, surprise” (p. 88). Each of these terms would merit a separate examination since they are already beginning to describe a horizon of clinical conceptualization quite apart from the psychoanalysis of the time.

In actuality, the patient is for Winnicott the point of departure of psychoanalysis: analysis is a practical task; if there is no patient there is no analysis. Then there is that “+”, which irrefutably expresses all that comes afterward - which are not the drives, the relationships, the fantasies, but instead the unconscious cooperation, the growth and use of intimacy. *Had we ever heard this language before Winnicott?*

It is in this perspective that we can position Winnicott in the belief that, through the intermediary of the transference, psychoanalysis is essentially *a relationship between two persons.*

### What the Depressed Patient Requires of His Analyst: Winnicott's Use of the Concept of Depression

While acknowledging a derivation from Freud's and Klein's previous pioneering works, a distinctive Winnicottian stamp is evident in the argumentative style of his early writings - a highly individual and personal tone in his choice of words that quickly renders his discussion of depression different from that of Klein. Simultaneously, however, another original thread in Winnicott's reflections on depression can be singled out; one that overlaps and is interwoven with the first, but that must be kept conceptually distinct in order for us to fully grasp its intrinsic meaning. I refer here to Winnicott's direct focus on *the essence of the psychoanalytic relationship itself*, i.e., on the intimate structure of that relationship's “textural” patterns. This can be surprising and disorienting because it seems incongruous within the context of the work in which it is placed.

Winnicott writes:

> The depressed patient requires of his analyst the understanding that the analyst's work is to some extent his effort to cope with his own (the analyst's) depression, or shall I say guilt and grief resultant from the destructive elements in his own (the analyst's) love.

*(1945, p. 138)*

This dense observation concentrates multiple lines of thinking that are only later explicitly articulated. What leaps out are the close ties that Winnicott establishes between psychoanalytic work and the analyst's personal work. He highlights his effort to cope with his own depression, and between this “job” and the task of analyzing lies the analyst's answer to the patient's demand.¹

---

¹ Although coming from a different perspective, Ogden (2001) was the first to underline this incredible Winnicottian observation.
Winnicott's perspective is rotated by 180 degrees with respect to the traditional one, previously taken for granted. According to him, analysis is possible only if the analyst is capable of working out his own depression in the course of his relationship with the patient. He must work toward resolution of his own psychic challenges in order to create a place inside himself from which to receive the patient's experience of depression. The analysis starts with the patient, but paradoxically it is first the analyst who has to create a place inside himself to allow analysis to start.

This also means that, in the presence of the patient, the analyst must revivify that dead internal object that is the analyst's “depressed mother” in order to live the depression of the patient's internal mother-object.

Depression in terms of the introjection of an internal dead object, the depressed mother, is an original conception of Winnicott's that is distinctively different from those of Freud and Klein - to whom, however, he makes reference. It is a unique conception that only later he will fully develop, starting from his essay on “Reparation in respect of mother's organized maternal defence against depression” (1948), and in greater detail in “Communicating and not communicating leading to a study of certain opposites” (1963a).

The analyst's response, says Winnicott, makes the difference from the outset in the way that the patient's depression develops, transforms, and is worked through (Bonaminio, 2008). This first implicit intuition emerges more strongly and finds its full expression in the paper “The use of the object”, where Winnicott says explicitly that it is the reality of the analyst which makes the difference, i.e. his being an “objective object” that survives the patient's attacks, not being the receptacle of the patient's attacks via projective identifications. It is to be noticed here that at this point of the development of his ideas, Winnicott's use, or better his very limited use, of the concept of projective identification is completely different from the Kleinian (over) use of it.

The analyst's response - his striving to be real and alive for the patient - gives a unique imprint to the analysis of depression on a technical level as well.

**Winnicott's Concept of Depression in His Theory of the False Self**

In his 1948 paper “Reparation in respect of mother's organized defence against depression”, Winnicott described the “false reparation” that we find in clinical practice: false because it is not specifically tied to the patient's guilt, but refers to another subject. This concept, radical when compared to the Kleinian notion of reparation, gives rise to his clinical discoveries on dissociation in connection with the false self (1960b).

At the outset of the 1948 paper, Winnicott observes that “this false reparation appears through the patient's identification with the mother, and the dominating factor is not the patient's own guilt but the mother's organized defense against depression and unconscious guilt”. Further on, he notes:
The depression of the child can be the mother's depression in reflection. The child uses the mother's depression as an escape from his or her own; this provides a false restitution and reparation in relation to the mother, and this hampers the development of a personal restitution capacity. (p. 91-93)

With these considerations, he is beginning to describe the psychic work done on behalf of the other from within the self, carried out through the process of identification. The scale of this work varies widely, until gradually it comes to include occupation of the self by the other.

**Toward a New Meaning of the Work of Interpretation**

In a surprising paper of 1959, uncannily entitled “Nothing at the centre”, Winnicott transmits a vivid image of the way in which he works clinically - a lively picture of his way of fantasying about and elaborating the clinical material:

The striking thing was what happened when I made a certain interpretation…

I interpreted that if nothing was happening for her to react to she came to the centre of herself where she knows that there is nothing. I said this nothingness at the centre is her tremendous hunger … As soon as the trend of my interpretation became clear to her … she fell dead asleep and stayed asleep for about twenty minutes. When she began to waken and to become impatient with having been to sleep and missed the hour, I began again on the interpretation, whereupon she went suddenly into a new sleep and stayed like it until the end of the hour. When she wakened she said: “I have been glued to the couch”…

This patient often goes to sleep. This time the sleep had a new quality … I assumed that the sleep represented a particular kind of resistance to the interpretation. The essence of interpretation was that there is a dissociated self which is nothing; it is nothing but a void … This is the first time that she and I in the course of four years analysis have found together a satisfactory statement of her true self and at the same time of her appetite. (p. 50)

This passage offers an example in vivo of the oscillation between the patient's communication and non-communication in the here and now of the session (Bonaminio 2001). It also illustrates the analyst's capacity to let himself go, to tolerate giving himself up to this wave-like movement, without forcing the patient to communicate - and at the same time maintaining his position as other.

In doing psycho-analysis I aim at:

Keeping alive;
Keeping well;
Keeping awake.
I aim at being myself and behaving myself. (1962, p. 166)

Here, in a paper whose classically technical title is “The aims of psychoanalytical treatment” - the author begins quite provocatively. He talks of
himself and makes reference to what is not so technical, but on the contrary very personal: i.e., the basic matrix of “staying” with the patient in the session.

Interestingly, Bion's (1967) well-known recommendation to the analyst to “suspend memory and desire” is, like Winnicott's statement, anything but “technical”. Like Winnicott, Bion emphasizes not a strategy of technique, but a position for the analyst to aim for in the consulting room, in the here and now of the session - a position that enables him both to stay with himself and to stay with the patient.

It is important to underline a notable distinction between Winnicott's position and Bion's. Whereas Bion highlights the analyst's mental functioning it is the integrity of the analyst's psyche-soma to which Winnicott first calls our attention. The activity of thinking is evoked by Bion's image; even when the analyst suspends thinking, what we see when we read Bion is a thinking analyst. The analyst described by Winnicott, in contrast, is someone whom we see simply breathing more than anything else. To Winnicott, the mind is an organized defense, a pseudo-integration that replaces and holds together a precarious psychosomatic integration; it protects the self from disintegration, from fragmenting into pieces.

Winnicott is speaking here of a live analyst capable of desiring what the analysand brings to the session and of remembering what he has brought in the past: an analyst with an emotional appetite for clinical material, and one who shows himself to be present - as we see in his undated paper “A point in technique”.

Bion's primary focus, derived from the Kleinian tradition, is on the various parts of the personality and on internal objects. Winnicott's attention, conversely, is directed mainly at the totality of the self and its oscillation from non-integration to integration and personalization. This difference in the vertices of observation is evidenced not only by the content of the two authors' reflections, but even by their grammatical choices, as in their contrasting uses of what and who in characterizing the psychoanalytic discourse.

“Containment” and “holding”, respectively, are other characteristic terms that encapsulate Bion's and Winnicott's unique points of view. A container (from which the term “containment” developed in Bion) is a thing, an object that performs a function akin to encircling or gathering in. In contradistinction, holding refers to a bodily posture and here again we see Winnicott's prevailing attention to the psychosomatic matrix.

The dreaming function implied in Bion's wonderfully evocative description of maternal reverie refers to mental operations as thinking activities. What is generally, and in my view wrongly, considered to be the Winnicottian counterpart to this Bionian concept pertains more to the affective and bodily dimension, the “primary maternal preoccupation” (1956), which first of all evokes the mother's breathing as she watches over her sleeping child. Here we find another expression of Winnicott's prioritization of “keeping alive, keeping well, keeping awake”.

Thus, as indicated, holding and container describe different functions and processes.
The Difference between Regression and Withdrawal

Additional elements of particular interest in the passage quoted from “Nothing at the centre” concern both interpretation and the issue of the manic defense.

“I interpreted that if nothing was happening for her to react to, then she came to the centre of herself where she knows that there is nothing” (1959, p. 50). Here, Winnicott's interpretation is precise and clear-cut, without pretense, and the space created in which interpretation can take place functions as the “transitional” element. Furthermore, the interpretation contains two significant elements.

First, there is defense analysis: “if nothing was happening for her to react to.” The Winnicottian concept of reacting to environmental impingement is present in the background, but this passage also uses clinical evidence to portray a bit of Winnicott's theory of impingement in vivo; second, there is a courageous, direct statement about a “void” within the patient: “at the centre” there is “nothing.” Paradoxically, this provides the patient with a sense of self that is somehow “full” in that it transmits something important; that is, because she and the analyst have “found together a satisfactory statement of her true self and at the same time of her appetite” (1959, p. 50), she experiences a “fullness” of her sense of self. The “statement” is “satisfactory” because it has satisfied the patient's appetite, filling her up. The internal void can begin its transformation into a presence through being experienced rather than denied via a manic defense. The “statement” is also “satisfactory” because it satisfies the appetite of Winnicott as analyst - that is, his desire to provide the analysand with a meaning that makes sense.

What analyst and patient have “found together” (1959) comes alive in the analyst's interpretation. What develops is a shared “illusory experience” (1951, p. 3), which at the same time is private and individual to the analysand. As Winnicott describes in his 1959 paper, it is in the sleep into which the patient falls - which, as Winnicott points out, “had a new quality” and “represented a particular kind of resistance to the interpretation” - that it is possible to identify the private side of the void that is denied by the manic defense. In this clinical situation, sleep in the session becomes a form of clinical withdrawal, a sort of pathological independence. Through the relationship with the analyst and his capacity to understand and tolerate this sleeping - without immediately interpreting it as an attack or a withdrawal from the work of analysis - the sleep becomes a regression to dependence.

Winnicott elaborates on this theme in “Notes on withdrawal and regression” (1965):

The correct word for the Wednesday session was withdrawal … With this patient it is extremely important that I understand the difference between regression and withdrawal. Clinically the two states are practically the same thing. It will be seen, however, that there is an extreme difference between the two. In regression there is dependence, and in withdrawal there is pathological independence … I have learned at the school of this analysis that withdrawal is something that I do well to allow.

(p. 149)
In “On transference” (1956), Winnicott has already taken up similar themes:

That which would be called resistance in work with neurotic patients always indicates that the analyst has made a mistake, or in some detail has behaved badly; in fact, the resistance remains until the analyst has found out the mistake and has tried to account for it, and has used it. It is here that we can see the sense in the dictum that every failed analysis is a failure not of the patient but of the analyst … The analyst [must] … look for his own mistakes whenever resistances appear.

(1956, p. 388, italics in original)

Going back to the distinction between withdrawal and regression, Winnicott differentiates between these two phenomena by focusing on the analyst's function and his capacity to tolerate the patient's resistance, which is indicative of the precise location of the patient's experience that corresponds to a failure on the analyst's part. In broader terms, the analyst's mistake might be seen as a failure of the primary holding environment.

What is crucial here is the distinction between object-mother and environment-mother (1963b, p. 75-76). This is important not only in terms of the theory of infant development, but primarily for its technical implications. In particular, the object-mother and the environment-mother are related to the Winnicottian concepts of subjective object or objective object, introduced in “Hate in the countertransference” (1947); these latter concepts are further developed in “The use of the object” (1969), which I will discuss later.

The following comments are particularly illuminating from a technical point of view:

I would say that in the withdrawn state a patient is holding the self and that if immediately the withdrawn state appears the analyst can hold the patient, then what would otherwise have been a withdrawal state becomes a regression. The advantage of a regression is that it carries with it the opportunity for correction of inadequate adaptation-to-need in the past history of the patient. … By contrast the withdrawn state is not profitable and when the patient recovers from a withdrawn state he or she is not changed.

(1954, p. 261, italics in original)

A “Very Simple Statement about Interpretation”

The interpretation of the 1959 paper is now clearer: the state of sleep - after Winnicott's interpretation of the manic defense with which she had maintained her dissociated self, which was “nothing” - indicates the moment in which withdrawal turns into regression. In the clinical situation, there is a patient who sleeps and an analyst, Winnicott, who “dreams” an interpretation about the patient. We are here facing a generative paradox, according to which an individual phenomenon, defensive withdrawal, is transformed into a state defined by the fact that the analyst participates in a relationship in which the patient is to some degree regressed and dependent.

The psychoanalytic situation is a paradoxical place in which the intrapsychic relationship between sleep on the one hand, and “the-dream-as-guardian-of-the-sleep” on the other, evolves into an intersubjective relationship, in which a part of the total operation is fulfilled by each participant.
The new quality of this sleep - an insight that transforms withdrawal into regression - had previously been “mused” by Winnicott, starting from the time of the patient's comment about having been “glued to the couch” (1959). Like dreaming, musing is rooted in somatic sensations and in experiencing them, i.e. Winnicott's unique attention to the “psychosomatic matrix”.

Winnicott muses and re-dreams about much more in relation to the patient's feeling of being glued to the couch than simply his interpretation. Through his consideration of her sensation as a “particular kind of resistance to the interpretation”, it is possible for us to grasp in vivo his conception of psychoanalytic interpretation, which he elaborates as follows: “I have always felt that an important function of the interpretation is the establishment of the limits of the analyst's understanding” (1963b, p. 189). The limits of the analyst's incomplete understanding - so incomplete as to generate “a particular kind of resistance” - become, in that precise moment, the somatic limits for the patient: in her feeling “glued to the couch,” what she has found is the boundary of her manic omnipotence.

Whenever Winnicott proposes an interpretation to the patient, he seems aware that this proposal's central aspect is not the disclosure of an unconscious fantasy, secluded and in some way fixed within the patient. On the contrary, the interpretation is a statement conveying an outlook on the state of the patient's self, an amplification of the emotional and relational meanings that the interpretation generates in the patient - who, in turn, sends them back to the analyst in a process of semantic circularity (Bonaminio, 1993). This is clearly portrayed in “Interpretation in psychoanalysis”:

> The purpose of interpretation must include a feeling that the analyst has that a communication has been made which needs acknowledgement …Giving an interpretation back gives the patient [an] opportunity to correct the misunderstandings. (1968a, p. 208-209)

Later in the same paper, Winnicott surprises us by saying that: “The principle that I am enunciating at this moment is that the analyst reflects back what the patient has communicated. This very simple statement about interpretation may be important precisely because it is simple (1968a, p. 209). In the expression “reflects back”, the paradox of the discovery of the self through the other finds its virtual point of refraction in an interpretation that “must include a feeling that the analyst has that a communication has been made which needs acknowledgement,” in Winnicott's words (p. 208).

In his delineation of the cross-dialectics within the consulting room, what comes to mind, naturally, is his paper on the mother's “mirror role” (1967). “What does the baby see when he or she looks at the mother's face? What the baby sees is himself or herself. In other words the mother is looking at the baby and what she looks like is related to what she sees there” (p. 131).

In Winnicott's reference to “the mother's role of giving back to the baby the baby's own self” (p. 138), his use of “giving back” is very similar to that of his “reflecting back” to the patient. Thus, the statement about the mother's role of giving back can be viewed as constituting the matrix with which to “metaphorize” the entire analytic relationship and the function of interpretation.
Winnicott continues:

This glimpse of the baby's and the child's seeing the self in the mother's face, and afterwards in the mirror, gives a way of looking at analysis and at the psychotherapeutic task. Psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving the patient back what the patient brings.

(1967, p. 137-138)

It is not only the dialectical interplay between self and other that Winnicott's paper on interpretation elucidates through reference to the analyst's function of reflecting back to the patient what the patient has communicated to him. We can here discern the explication of a detailed clinical theory that illuminates the function of interpretation in the fragment of analysis with the patient described in “Nothing at the centre”. Winnicott writes:

The patient can be giving the analyst a sample of the truth; that is to say of something that is absolutely true for the patient, and when the analyst gives this back, the interpretation is received by the patient who has already emerged to some extent from this limited area or dissociated condition.

(1968a, p. 209)

Here Winnicott's conception of pathological dissociation is brought into the very intimate texture of the analytic relationship; a fact of the single patient becomes a fact of the analytic relationship of both analyst and patient. Nevertheless, in that very moment, the patient “has already emerged to some extent from this limited area or dissociated condition” (1968a, p. 209). I see here a generative Winnicottian version of Freud's (1933) famous statement, “where id was, there ego shall be” (p. 80).

**Winnicott's Future Developments in Psychoanalysis**

Winnicott's paper, “The use of an object” (1969), begins provocatively and revolutionarily as follows: “I propose to put forward for discussion the idea of the use of the object. The allied subject of relating to object seems to me to have had our full attention” (p. 711). It is here that Winnicott makes clear the distinction between “subjective object” and “objective object”.

Winnicott introduces a distinction scarcely mentioned in the work of other authors and has at times been misunderstood. In a paper originally presented in 1968(b) entitled, “The use of an object and relating through identifications”, he writes:

What I have to say in this present chapter is extremely simple … It is only in recent years that I have become able to wait and wait for the natural evolution of the transference arising out of the patient's growing trust in the psychoanalytic technique and setting, and to avoid breaking up this natural process by making interpretations … It appalls me to think how much deep change I have prevented or delayed in patients in a certain classification category by my personal need to interpret. If only we can wait, the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more than I used to enjoy the sense of having been clever.

(1968b, p. 86, italics in original)
Each sentence from this quotation could be discussed in depth. I will highlight only the following points:

- Winnicott makes a clear-cut and clinically useful distinction between interpreting, which is a particular form of the analyst's inner psychic activity, and making an interpretation, as in the verbal interpretive comment conveyed to the analysand.
- Crucial to the success of treatment is the analyst's capacity to wait for the natural evolution of the transference, which can arise only out of the analysand's trust in the psychoanalytic technique and setting.
- Winnicott warns that an interpretation can potentially interrupt a natural process, which means that it can be experienced by the patient as traumatic if the analyst lacks sensitivity (to be able to accurately determine what to interpret), tactfulness (to know how to interpret), or timing (to know when to interpret).
- Winnicott's comment about “how much deep change” can be “prevented or delayed” by the analyst's “personal need to interpret” - that is, his own narcissism - must not pass unnoticed.

Winnicott then puts forth the groundbreaking statement mentioned earlier. He writes:

I think I interpret mainly to let the patient know the limits of my understanding. The principle is that it is the patient and only the patient who has the answers. (1968, p. 86)

Here, interpretation abandons the realm of the analyst's pretense of omnipotently knowing everything about the patient's unconscious feelings, drives, and desires. Instead, the analyst recognizes the limits of his understanding and presents himself to the patient as a real object that can be used for the patient's benefit.

This raises questions regarding the nature of the object. Some authors believe that the core problem dealt with in Winnicott's 1968 paper on “the use of the object” is the introjection of a surviving object together with the non-surviving object. In my view, this aspect comes after a more important step that precedes this introjection. That is, Winnicott is trying to expand a view of the subject vis-à-vis the object, along a trajectory which was initiated when he described, as early as 1942, the subjectivation meaning of the period of “hesitation”. For Winnicott the object here is not only the “internal object” created as the result of infant/patient projections, but a real object - real not in the sense of external.

The object as real is determined by its capacity to survive attacks. Surviving the attack does not mean simply surviving, but also implies that the object may well be wounded from this attack yet it is nonetheless able to survive. It is this dynamic that returns to the infant/patient in analysis the sense that the object who survives is real, hard, tough, capable of standing up, that it is something against which his (the infant/patient's) omnipotence breaks and falls.

In conclusion, I tried to show in this paper that Winnicott's psychoanalytic work with adults served as a lens through which he was able to understand early development of the self and its distortions. This stands in
opposition to the common belief that it was Winnicott's paediatric revolutionary theory of infant-environment relationships that influenced his clinical work.

References


