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Dependence in Infant Care, in Child Care, and in the Psycho-Analytic Setting[11]

D. Winnicott

There is nothing new in the idea of dependence, either in the early life of the individual or in the transference which develops force as a psycho-analytic treatment gets under way. What I feel may need restating from time to time is the relationship between these two examples of dependence.

I need not quote from Freud. Dependence of the patient on the analyst has always been known and fully acknowledged, and for instance shows in the reluctance of an analyst to take on a new patient within a month or two of a long summer holiday. The analyst rightly fears that the patient's reaction to the break will involve deep changes that are not yet available for analysis. I will start with a development of this theme.

> *A young woman patient had to wait for a few months before I could start, and then I could see her only once a week; then I gave her daily sessions just when I was due to go abroad for a month. The reaction to the analysis was positive and developments were rapid, and I found this independent young woman becoming, in her dreams, extremely dependent. In one dream she had a tortoise, but its shell was soft so that the animal was unprotected and would therefore certainly suffer. So in the dream she killed the tortoise to save it the intolerable pain that was coming to it. This was herself and indicated a suicide tendency, and it was to cure this tendency that she had come for treatment.*
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> *The trouble was that she had not yet had time in her analysis to deal with reactions to my going away, and so she had this suicidal dream, and clinically she became physically ill, though in an obscure way. Before I went I just had time, but only just, to enable her to feel a connexion between the physical reaction and my going away. My going away reenacted a traumatic episode or series of episodes of her own babyhood. It was in one language as if I were holding her and then became preoccupied with some other matter so that she felt*

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annihilated. This was her word for it. By killing herself she would gain control over being annihilated while dependent and vulnerable. In her healthy self and body, with all her strong urge to live, she has carried all her life the memory of having at some time had a total urge to die; and now the physical illness came as a localization in a bodily organ of this total urge to die. She felt helpless about this until I was able to interpret to her what was happening, whereupon she felt relief, and became able to let me go. Incidentally her physical illness became less of a threat and started to heal, partly of course because it was receiving appropriate treatment.

If illustration were needed this might show the danger of underestimating transference dependence. The amazing thing is that an interpretation can bring about a change, and one can only assume that understanding in a deep way and interpreting at the right moment is a form of reliable adaptation. In this case, for instance, the patient became able to cope with my absence because she felt (at one level) that she was now not being annihilated, but in a positive way was being kept in existence by having a reality as the object of my concern. A little later on, in more complete dependence, the verbal interpretation will not be enough, or may be dispensed with.

You will have observed that I could go in either of two directions, starting from such a fragment from an analysis. One direction would take us to the analysis of reaction to loss and so to the main part of that which we learn in our psycho-analytic training. The other direction

[1] *A paper read to the Boston Psychoanalytic Society, October, 1962.*

takes us to that which I wish to discuss in this paper. This other direction takes me to the understanding we have in us that makes us know that we must avoid going away just after starting an analysis. It is an awareness of the vulnerability of the patient's ego, the opposite of ego-strength. In innumerable ways we meet our patient's needs because we know what the patient is feeling like, more or less, and we can find the equivalent of the patient in ourselves. What we have in ourselves we can project, and find in the patient. All this is done silently, and the patient usually remains unaware of what we do well, but becomes aware of the part we play when things go wrong. It is when we fail in these respects that the patient reacts to the unpredictable and suffers a break

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in the continuity of his going-on-being. I wish to take up this point in particular later on in this paper, in discussing Zetzel's Geneva Congress paper (1956).

My general objective is to relate dependence in the psycho-analytic transference to dependence at various stages of infant and child development and care. You will see that I am involved in an attempt to evaluate the external factor. May I be allowed to do this without being thought to be going back on what psycho-analysis has stood for over the past forty years in child psychiatry. Psycho-analysis has stood for the personal factor, the mechanisms involved in individual emotional growth, the internal strains and stresses that lead to the individual's defence organization, and the view of psycho-neurotic illness as evidence of intrapsychic tension that is based on id drives that threaten the individual ego. But here we return to ego vulnerability and therefore to dependence.

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

If we accept the idea of dependence, then we have already started to examine the external factor, and indeed when we say an analyst should be trained we are saying that an essential for orthodox psycho-analysis is an external factor, that is to say the *good enough analyst*. All this is self-evident, yet I can still find those who *either* never mention this external factor as if it were really important, *or else* talk about it all the time, ignoring the internal factors in the process. As Zetzel said in a seminar recently: first Freud thought all neurotic persons had had sexual traumata in childhood, and then he found that they had had wishes. And then for several decades it was assumed in analytic writings that there was not such a thing as a real sexual trauma. Now we have to allow for this too.

In a deliberate examination of the external factor, I am thus far engaged in relating the analyst's personality, capacity for identifying with the patient, technical equipment, and so on, with the multifarious details of child care, and then in a more specific way with the special state that a mother is in (father maybe too, but he has less opportunity to show it) in the short time space covering the later stages of pregnancy and the first months of the infant's life.

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Psycho-analysis as we learn it is not at all like child care. In fact, parents who interpret the unconscious to their children are in for a bad time. But in the part of our work as analysts that I am referring to there is nothing we do that is unrelated to child-care or to infant-care. In this part of our work we can in fact learn what to do from being parents, from having been children, from watching mothers with very young babies or babies unborn, from correlating parental failures with subsequent clinical states of ill children. While we know that psychoneurotic illness is not caused by parents, we also know that the mental health of the child cannot become established without good enough parental or maternal care. We also know that a corrective environmental experience does not directly cure the patient any more than a bad environment directly causes the illness structure. I refer to this again at the end of this paper.

> *I now wish to refer back to my fragment of clinical material. Very early in the analysis this patient had become represented in her dream material by frail and often maimed creatures, and now she had dreamed of the tortoise with a soft shell.*[2] *You will have noted that this points the way to a regression to dependence that is bound to come. The patient had had several years of analysis along ordinary lines by an analyst who disallowed*

[2] *By the way, she could also be a horse that had to be shot, else it would have kicked its way out of an aeroplane.*

> *regression if this threatened to become acted out and to involve dependence on the analyst. She was therefore over-ripe for this part of the total analytic procedure, though of course needing as much as anyone else does the usual interpretations that become appropriate from day to day, or from minute to minute.*

If I go a little further into the interpretative problem in the analysis of this fragment, I think I can show how interwoven are these two things: the intrapsychic mechanisms and dependence, which by definition involves the environment and its behaviour.

> *I had plenty of material in this case for the interpretation of the patient's reaction to my going away in terms of oral sadism belonging to love reinforced by anger—anger with me and all the others in her life who have gone away, including the mother who weaned her. I could have weighed in, fully justified in terms of what the patient had*

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told me, but then I should have been a bad analyst making good interpretations. I should have been a bad analyst because of the way the material had been given me. All the time in our analytic work we are assessing and reassessing the ego strength of the patient. The material had been given me in a way that indicated that the patient knew she could trust me not to use it brusquely. She is hypersensitive to all drugs and to all illnesses and to slight criticisms, and I must expect her to be sensitive to any mistake I make in my estimation of the strength of her ego. Something central in her personality only too easily feels the threat of annihilation; clinically of course she becomes tough and extremely independent, well-defended, and along with this goes a sense of futility and of being unreal.

In fact her ego is not able to accommodate any strong emotion. Hate, excitement, fear—each equally separates off, like a foreign body, and all too easily becomes localized in a bodily organ which goes into spasm and tends to destroy itself by a perversion of its physiological functioning.

The reason why the regressive and dependence dreams have appeared has to do chiefly with her finding that I do not use every bit of material for interpretation, but that I store everything up for use at the right moment and content myself for the present with making preparation for meeting the dependence that is coming up. This dependence phase will be very painful for the patient, and she knows it, and a risk of suicide goes with it, but, as she says, there is no other way. There *is* another way, for if her analyst is not able to meet her dependence so that the regression becomes a therapeutic experience, she will break down into psychosomatic illness, which produces the much-needed nursing but not the insight or the mental care that can really make a difference. The analyst needs to know why the patient would rather kill himself or herself than live under threat of annihilation.

By looking at this bit of material in this way, we reach a point where we are discussing both analysis and the meeting of dependence needs. A string of 'good' interpretations relative to the general content of the session would produce anger or excitement, and it is not yet possible for this patient to deal with these all-out emotional experiences. It would therefore be bad in the sense of my present statement of analytic procedure to interpret the very things that are relative to the premature separation.

In the course of a talk in which we made plans for the future and discussed the nature of her illness and the risks that are inherent in

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going on with the treatment, I said:[3] *'So here is yourself ill, and we can see that the physical illness hides an extreme reaction to my going away, although you are not able to reach to a direct feeling-awareness of this. So that you could say that I have caused your illness, just as others have caused you to be ill when you were a baby, and you could be angry.' She said: 'But I'm not.' (Actually she holds me in an idealized position at present, and tends to find doctors of the body to be persecutors.) So I said: 'The path is there, wide open for your hatred and anger, but anger refuses to walk down the path.'*

The patient told me that the main thing that brought about the very swift, involuntary development towards dependence was the fact that I let things be, and wanted to see what each hour would bring. Actually the pattern had been that she would start almost as if the hour were a social visit. She would lie down and display very clear intellectual awareness of herself and of her surroundings. I played in with all this, and there was much silence. Near the end of each hour she would quite unexpectedly

[3] *I was clearly affected by the intellectual level of her method of presenting material.*

remember a dream, and she would then get my interpretation. The dreams presented in this way were not very obscure, and the dream resistance could usually be seen to reside in the 45 minutes of material that preceded it and that was not good material for interpretation. That which has been dreamed and remembered and presented is within the capacity of the ego-strength and structure.

So this patient will be very dependent on me over a phase; the hope is that for her sake, as well as for mine, this dependence will be kept within the confines of the transference and of the analytic setting and sessions. But how can one tell in advance? How can one make this sort of diagnosis that is concerned with assessment of needs?

In terms of *child-care*, I would like to exemplify regression in the service of the ego by looking at the phases of spoiling which parents find one child needs from time to time—parents, that is, who do not spoil their child because of their own anxieties. Such phases of spoiling bring many a child through without any involvement of a doctor or a child guidance clinic. It is difficult to give a case without making it sound rare, and these are matters of common experience in

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family life, when parents care for their own children. For a few hours, or days, or weeks, in a special context, a child is treated as if of a younger age than is in fact true chronologically. Sometimes it happens when a child bangs his head or cuts his finger; he goes in a moment from 4 to 2, and is screaming and consoling himself with his head in his mother's lap. Then in no time, or after a sleep, he is again very grown up, and more so than his own age warrants.

> *Here is a boy of 2 (Winnicott, 1963). He reacted very badly at 20 months to the mother's anxiety which she experienced when she conceived. It is part of her pattern to become extremely anxious at conception. He stopped using the pot and stopped using words, and his forward progress was held up. When the baby was born he was not hostile to the baby, but he wanted to be bathed like the baby. At breast-feeding time he started thumb-sucking, which had not previously been a feature. He made special claims on the parents' indulgence, needing to sleep in their bed for many months. His speaking was delayed.*
>
> *The parents met all these changes and demands in a satisfactory way, but the neighbours said that they were spoiling the boy. Eventually the boy emerged from his regression or withdrawal and the parents were able to finish with spoiling him when he was 8 years old, after he had had a phase in which he was stealing money from them.*[4]

This is a common type of case in child psychiatry as I know it, especially in private practice when children are brought for symptoms that in child guidance might be considered to be insignificant. It has been an important part of my child psychiatry orientation to recognize that in such a case one does not immediately think of psycho-analysis; one thinks of supporting these parents in their management of their child's babyishness. One may be in a position, of course, to give psycho-analytic help, while the parents are carrying out the mental nursing of the patient, but it is a formidable matter to treat such a case by psycho-analysis if there is not a parental provision that will meet the mental nursing needs. Without the parents' mental nursing the psycho-analyst doing psycho-analysis must find the patient not only dreaming of being taken over by the analyst and into his or her home, but also actually needing to be taken in.

A corollary of this that when an orthodox psycho-analysis of a child is successful there is an acknowledgement to be made by the psycho-analyst that the parents' home, relations, helpers, friends, etc., did nearly half the treatment. We do not have to make these acknowledgements out loud, but we need to be

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honest about these matters of the patient's dependence when we are theory-building.

Now I come to the earlier *infant-mother relationship*. A great deal has been written about this. I want to draw your attention to the part the mother plays at the time of her baby's very great dependence at the beginning. Although I believe readers are fully aware of these matters, I wish to go over the argument again so that it can be discussed.

Here I wish to refer to a paper by Zetzel (1956). I need not gather together all the threads that

[4]*Miss Freud has recently (1963) taken up the subject of ego-regression in a paper published in the Menninger Bulletin.*

went to the making of this very valuable review of Current Concepts of Transference. I only want to take out of her paper the paragraphs in which she refers to my own work. She writes: 'Other analysts—Dr Winnicott, for example—attribute psychosis mainly to severe traumatic experiences, particularly of deprivation in early infancy. According to this point of view, profound regression offers an opportunity to fulfil, in the transference situation, primitive needs which had not been met at the appropriate level of development. Similar suggestions have been proposed by Margolin and others ...'

It is valuable to me to have the opportunity to take up this description of my attitude to this subject, a subject that has great importance because of the fact that one of the growing points of psycho-analysis is in the treatment of the borderline case and in the attempt to formulate a theory of psychotic illness, especially schizophrenia.

Firstly, do I attribute psychosis mainly to severe traumatic experiences, partly of deprivation in early infancy? I can well understand that this is the impression that I have given, and I have changed the way I present my view in the course of the past decade. It is necessary, however, to make some corrections. I have definitely stated that in the aetiology of psychotic illness and particularly of schizophrenia (except in so far as hereditary elements are operative) there has to be noted a failure in the total infant-care process. In one paper I went so far as to state: 'Psychosis is an environmental deficiency disease'. Zetzel uses the term 'severe traumatic experiences', and these words imply bad things happening, things that look bad from the observer's point of view. The deficiencies that I am referring to are failures of basic provision—like my going

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away to the U.S.A. when my patient is not ready for the reactions that occur in her to my going. In other papers I have explored in great detail the kinds of failure that constitute failure of basic provision. The main point is that these failures are unpredictable; they cannot be accounted for by the infant in terms of projection, because the infant has not yet reached the stage of ego structuring that makes this possible, and they result in the *annihilation* of the individual whose going-on-being is interrupted.

Mothers who are not themselves ill do in fact avoid this type of failure of care of an infant.

Under the heading 'Primary Maternal Preoccupation' I have referred to the immense changes that occur in women who are having a baby, and it is my opinion that this phenomenon, whatever name it deserves, is essential for the well-being of the infant. It is essential because without it there is no one who is sufficiently identified with the infant to know what the infant needs, so that the basic ration of adaptation is missing. It will be understood that I am not just referring to adaptation in terms of the satisfying of id-drives.

A basic ration of environmental provision facilitates the very important *maturational developments* of the earliest weeks and months, and any failure of early adaptation is a traumatic factor interfering with the integrative processes that lead to the establishment in the individual of a self that goes on being, that achieves a psychosomatic existence, and that develops a capacity for relating to objects.

So a statement of my view would include the following:

i. It is in psychoneurotic illness that we find the conflicts that are truly personal to the individual, and relatively free from environmental determinants. One needs to be healthy enough at the toddler age to achieve psychoneurotic illness, let alone health in this area.

ii. It is in the earlier stages that the basis of the mental health of the individual is being laid down. This involves:

a. maturation processes, which are inherited tendencies, and

b. the environmental conditions that are needed if the maturational processes are to become actual.

In this way, failure of early basic environmental provision disturbs maturation processes, or prevents their contributing to the individual child's emotional

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growth, and it is this failure of the maturation processes, integration, etc., that constitutes the ill-health that we call psychotic. This failure of the environmental provision (privation) is not usually referred to by the word 'deprivation', hence my need to correct the words of Zetzel's reference to my work.

iii. A complication in the making of this statement is the fact that there is an intermediate position, one in which environmental provision is at first good, and then fails. It succeeds in that it allows of ego organization of considerable degree, and then it fails at a stage before the individual

has become able to establish an internal environment—that is, to become independent. This is what is usually called a 'deprivation', and it does not lead to psychosis; it leads to a development in the individual of an 'antisocial tendency', which may in turn force the child into having a character disorder and becoming a delinquent and a recidivist.

All these over-simplifications need elaboration which I have given them elsewhere but which I cannot gather together here. I wish, however, to refer briefly to a few of the effects of this attitude to mental disorder on our way of thinking.

i. One is that it is in the psychoses—not in the psycho-neuroses—that we must expect to find examples of self-cure. Some environmental happening, perhaps a friendship, may provide a correction of a failure of basic provision, and may unhitch the catch that prevented maturation in some respect or other. In any case, it is sometimes the very ill child in child psychiatry who can be enabled to start growing by snack-bar psychotherapy, whereas in the treatment of psychoneurosis one always wants to be able to provide a psycho-analytic treatment.

ii. The second is that a corrective experience is not enough. Certainly no analyst *sets out to provide* a corrective experience in the transference, because this is a contradiction in terms; the transference in all its details comes through the patient's unconscious psycho-analytic process, and depends for its development on the interpreting that is always relative to material presented to the analyst.

Of course, the practising of a good psycho-analytic technique *may* in itself be a corrective experience, and for instance in analysis a patient may for the first time get full attention from another person, limited though it be to the reliably

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established 50-minute session; or may for the first time be in contact with someone who is capable of being objective. And so on.

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

So in the end we succeed by failing—failing the patient's way. This is a long distance from the simple theory of cure by corrective experience. In this way, regression can be in the service of the ego if it is met by the analyst, and turned into a new dependence in which the patient brings the bad external factor into the area of his or her omnipotent control, and the area managed by projection and introjection mechanisms.

Finally, in regard to the patient to whom I have referred, I must not fail in the child-care and infant-care aspects of the treatment until at a later stage when *she will make me fail* in ways determined by her past history. What I fear is that by giving myself the experience of a month abroad I may have already failed prematurely and have joined up with the unpredictable variables of her infancy and childhood, so I may have truly made her ill now, as indeed the unpredictable external factors did make her ill in her infancy.

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