

# HOW D. W. WINNICOTT CONDUCTED PSYCHOANALYSIS

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This study, based largely on interviews with people who had known D. W. Winnicott, including 6 who had been in analysis with him, describes how he conducted psychoanalysis. Winnicott, it is argued, developed an innovative approach to treatment that emphasized “holding” and de-emphasized interpretation. The chief topics covered are: his attempt to develop an approach suited to patients with conditions more serious than neuroses, his view of interpretation, the role of the analyst’s mistakes and failures, the holding environment, adaptation to need, the use of the object, and the details of his interactional style. Winnicott’s clinical theory, that is, his explanations of how he sees the psychoanalysis he practiced as working, is related to, and illustrated by, his analysands’ accounts of being in treatment with him.

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In the latter part of his career, Donald W. Winnicott developed an innovative psychoanalytic approach that emphasized “holding” and de-emphasized interpretation. Although in his publications he described the clinical theory behind his method of treatment, he wrote little about what his approach means in practice. He avoided such descriptions, according to Margaret I. Little, because “in treating adults a very high degree of confidentiality was needed. Some of his patients were colleagues or students in training, and some were prominent or well-known people” (Little, 1985, p. 3). M. Masud R. Khan (1989), who assisted Winnicott in much of his writing, made a similar observation: “The reason for the paucity and absence of clinical material in his papers . . . is that D.W.W. was very particular about guarding the privacy of his patients . . .” (p. 27). I suspect that Winnicott also knew how controversial his methods were and hence he was reluctant to expose himself to disparagement from the psychoanalytic community.

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In the 1980s, I interviewed a number of people who were familiar with Winnicott and his work. Among these were six people who had been in analysis with Winnicott. Four of them were psychoanalysts: Little, Khan, Marion Milner, and Enid Balint. The other two were Rosemary Dinnage, a prominent essayist and book reviewer, and a man who wished to remain anonymous (whom I refer to as Mr. B). All gave me permission to use, in my writing about Winnicott, what they told me about their experiences with him. In this article, relying heavily on the interviews (further supplemented by published material), I seek to add to our knowledge of how Winnicott conducted psychoanalysis (I will use the terms, "psychoanalysis" and "analysis," in the broad sense that includes what we might call psychoanalytic psychotherapy).

### Winnicott's General Approach to Conducting Psychoanalysis

I especially looked forward to the interview with Margaret Little. I knew her to be a distinguished psychoanalytic clinician and author and a pioneer in the understanding of countertransference. Little (1981, November 1) shocked me with the bluntness of her first words as she began telling me about her analysis: "If I hadn't been helped by Winnicott, I would have committed suicide or I would have become a chronic mental patient." "Analysis with D. W. did not do away altogether with depression or anxiety, or even paranoid fears," Little (1982) later explained. "It provided the means of resolving them, and made it possible to continue with self-analysis even many years after termination. I owe him my life and any sanity I possess."

What, in general, was the approach Winnicott took? One of his comments captures it best (Rodman, 1987, p. 62): "the mothering technique is handed over to the analyst and what I have called the true self comes out of safe hiding . . . and risks living in the new environment I am able to provide, at any rate in token form in the analytic setting." It is not surprising that this, the most direct statement he made about his way of doing analysis, came, not in a published work, but in a letter to a colleague (W. Clifford M. Scott) whom he could count on to be sympathetic.

Winnicott's principal contribution to psychoanalytic theory is his analysis of child development, with an emphasis on the child's experience early in life within the maternal matrix. Just as his account of child development shows how a child may come to have an existence handicapped by a false self, his approach to psychoanalysis revolved around enabling a patient to turn over the false self to the analyst and helping provide conditions which would make it possible for the true self to come into its own. "Winnicott modeled his clinical orientation to the patient," Khan (1971) noted, "largely on 'an ordinary devoted mother's' holding care of her infant" (p. 225). Winnicott did not simply "mother" his patients, but he did try to do what the "good enough" mother does, that is, to provide attention, care, and security so that the patient's innate maturational processes would be able to take over. One former patient (Mr. B., 1981) told me that in his professional work he had observed no fewer than 10,000 mothers and yet "Winnicott was the best mother I ever met."

### "Change the Technique, Not the Patients"

The consensus early in Winnicott's career was that there was only one kind of patient appropriate for psychoanalysis—the neurotic patient who would be able to develop a transference neurosis—and only one kind of treatment. Winnicott called that kind of treatment

“classical” psychoanalysis (Winnicott, 1963a, p. 231) or “standard” psychoanalysis (Winnicott, 1962, p. 168). He described its aim as being for the analyst “to verbalize the nascent conscious in terms of the transference” (Winnicott, 1962, p. 170), a statement that combines two of Sigmund Freud’s basic tenets, that the goal of psychoanalysis is to make the unconscious conscious and that psychoanalytic treatment is marked by the development of a transference neurosis.

During the period of Winnicott’s early career, the 1930s and 1940s, the question was whether a patient was analyzable. If not, the expectation was that the patient would be rejected for treatment. Such an approach was not unreasonable; psychoanalysts believed from experience that their technique could not help these patients who did not fit the neurotic paradigm. According to Martin James (1981), who was speaking with me about his personal knowledge of Winnicott, “Ferenczi believed, you change the technique, not the patients. So did Winnicott. You take everyone, and you figure out how to treat [that individual].” Changing the patient refers to rejecting a patient who was not seen as analyzable and replacing that person with someone considered analyzable. Winnicott (1959–1964, p. 126) made a similar comment in one of his papers. He noted that “failure to deal with psychotic manifestations in childhood meant for [Melanie Klein] (as for Ferenczi) a failure of technique not of selection.” Winnicott saw his project as developing a way of treating the patients who had been deemed unanalyzable.

Using the diagnostic language available at the time, he referred to these patients as “borderline” (Winnicott, 1963a, p. 239), “schizoid” (Winnicott, 1963a, pp. 239–240), or “psychotic” (Winnicott, 1959–1964, p. 129). Little (1985) too used the word, “psychotic,” and even gave the word a central place in her classic paper about her analysis with him, “Winnicott Working in Areas Where Psychotic Anxieties Predominate: A Personal Record.” In one of my interviews with her, I asked what the English analysts mean by “psychotic,” as it seemed to me they used the word differently than we did in the United States. For us, I said, “psychotic” means being out of touch with reality. Little (1986) explained that she was referring to “anxieties being concerned with identity and existence.” Winnicott (1959–1964) made a similar comment that the psychoanalyst will see the patient’s diagnosis as being psychosis not neurosis “where annihilation anxiety, not castration anxiety, is found as an important feature” (p. 129).

Winnicott’s central point was that classical technique was ineffective with patients who had what he called a false-self existence. He said that he observed analyses which went on “indefinitely because they are done on the basis of work with the False Self.” Winnicott (1960) further noted:

In one case, a man patient who had had a considerable amount of analysis before coming to me, my work really started with him when I made it clear to him that I recognized his nonexistence. He made the remark that over the years all the good work done with him had been futile because it had been done on the basis that he existed, whereas he had only existed falsely. When I had said that I recognized his nonexistence he felt that he had been communicated with for the first time. What he meant was that his True Self that had been hidden away from infancy had now been in communication with his analyst in the only way which was not dangerous (p. 151).

At another time Winnicott (1971, pp. 86–87) said that analyst and patient may join in considering the patient to be “psychoneurotic (as opposed to mad).” In such cases, after termination, “the patient knows that there has been no change in the underlying (psychotic) state and that the analyst and the patient have succeeded in colluding to bring about a failure.”

Little's account to me of her experience illustrates just the situation that Winnicott describes here. With a highly respected senior analyst, Ella Sharpe, Little had a treatment that also served as her training analysis, from 1940 to 1947. Little (1981, November 1) told me, "I am angry at Sharpe. She didn't touch my illness, and I knew it. I had a real illness which she couldn't see. She thought I was a hysteric; I wasn't. She thought I had troubles with my Oedipus complex. But I had never grown to that point. One time I said to her, 'I'm not sure I'm alive at all.' She saw this as castration anxiety." The analysis continued to the point at which they had an agreement to terminate. Before they could end formally, Sharpe died. Little (1981, p. 273) noted, "I knew that none of my real problems had been touched."

Little (1981, p. 273) said that, by contrast, Winnicott "recognized my psychotic anxieties and provided the 'facilitating environment,' and the 'good enough' holding that I needed." He helped her understand how her mother's unpredictability had created chaos within her. Little (1982) explained that he "released me from the grip of that chaos, and from my 'false self,' so that I could begin to find the 'real' me which I had never known, and to find a different world, a real one in which the real self could live and function differently."

Dinnage (1982, July 15), hearing from me about what Little had told me, commented that her experience was eerily similar to Little's. Before starting with Winnicott, she had had multiple periods of psychoanalysis that did not seem to touch on her deeper problems. "With every other analyst the misery of analysis to me has been the way they don't understand . . .," Dinnage (1981, October 27) remarked. "When you get to the vital thing, somehow they're dreaming or they tell you it means something else. I didn't feel that with Winnicott. We seemed to be sort of just grooving into our unique dual language between the two of us."

Guntrip (1975) too, in his written account of being in analysis, first with Ronald Fairbairn, later with Winnicott, stated that, although there was value in his earlier analysis, something vital was lacking. "Fairbairn did not have the same capacity for natural, spontaneous 'personal relating' that Winnicott had" (p. 146), he noted. Guntrip found Fairbairn "gradually falling back on the 'classical analyst' with an 'interpretative technique,' when I felt I needed to regress to the level of that severe infancy trauma" (p. 146). Later Winnicott, according to Guntrip, "[Entered] into the emptiness left by my nonrelating mother, so that I could experience the security of being my self" (p. 155).

Winnicott noted at various times (e.g., Winnicott, 1989, p. 581) that during much of his career he practiced the more traditional form of analysis that emphasizes the making of interpretations. Later in his career, as Winnicott (1962, p. 169) put it, "When I am faced with the wrong kind of case I change over into being a psychoanalyst who is meeting the needs, or trying to meet the needs, of that special case." By "the wrong kind of case," he means the patient is not neurotic. The neurotic cases, he observed, are "getting rare" (Winnicott, 1963a, p. 231). Similarly, he said another time, "Our patients, more and more, turn out to be needing to feel real, and if they don't then understanding is of extremely secondary importance" (Winnicott, 1989, p. 582). Winnicott developed a form of "modified analysis" (Winnicott, 1962, p. 168) that he envisioned as the kind that would be used increasingly.

In one of his summaries of his approach, Winnicott (1955-1956) commented:

The behavior of the analyst, represented by what I have called the setting, by being good enough in the matter of adaptation to need, is gradually perceived by the patient as something that raises

a hope that the true self may at last be able to take the risks involved in its starting to experience living.

Eventually the false self hands over to the analyst. This is a time of great dependence, and true risk, and the patient is naturally in a deeply regressed state. (By regression here I mean regression to dependence and to the early developmental processes, p. 297).

### Did Winnicott Get His Patients' Hopes up Too Much?

That quotation, in which Winnicott speaks of raising a patient's hope of becoming able to live through the true self, brings to mind my interview with Enid Balint (1981). Not only a noted psychoanalytic writer, she was the widow of another major contributor to the field, Michael Balint. To her I said I understood Winnicott was particularly effective at working with schizoid patients. Looking surprised, she replied, "Michael would have laughed at that." (Incidentally, she also noted that Michael Balint respected Winnicott's clinical work and recognized his outstanding intelligence.) She explained, "I think Winnicott got up their hopes too much that all their needs would be answered. It wasn't that he said so directly, it was his general manner." It is impossible to fulfill the needs of such patients, she said, except possibly in a mental hospital, such as Chestnut Lodge, which provides full-time treatment. She said she knew of some cases in which Winnicott failed. And, in fact, Winnicott's biographer, F. Robert Rodman (2002), also talks of some of Winnicott's disappointing treatments, including some that ended in suicide.

I asked others what they thought of Enid Balint's comment. One of Winnicott's former patients (Mr. B., 1981) said he was convinced Winnicott did not arouse hopes that he could not fulfill. "This did not happen with me or with anyone I know," he claimed. "He gave me a feeling of being let into a new world. At the same time, he gave me the feeling I had experienced it before. Both of those. I know that's a paradox. I always found him good enough." Khan (1981, November 11) said that in part he shared Balint's criticism; he felt that Winnicott sometimes raised his patients' hopes too far. "But who doesn't?" he asked. "Freud said, 'Where id was, there ego shall be.' What about that?"

Balint (1981), despite her negative comment about Winnicott's work with schizoid patients, told me that she benefited enormously from her own 5-year analysis with him in the early 1950s. "He let me be for quite a long time," she recalled. "It was just what I needed. He never said anything about the Oedipus complex or objects in my life. He never made obvious interpretations. I experienced quite deep things." I asked whether he was effective at providing a therapeutic environment and allowing her to feel secure. "Oh, it was much more than that," she replied. "I would experience quite a lot of regression during the sessions, then go and see my own patients."

In an interview with Peter Rudnytsky (2000, pp. 23–24), Balint provided more detail about her analysis with Winnicott. "He knew I needed something that he could give me," she said. "He joined me up." At the beginning of her analysis, Balint thought everyone was like her in that "everybody had an ache in their bodies and in their back. I mean, that there was a division between the top and bottom of everyone." She found it to be "the most painful bit of my analysis—absolutely dreadful— . . . when I was joined up. And he did that for me, which was quite remarkable." "What I relived presumably was the moment when I was broken," she noted. Her speculation is "my mother wanted to get rid of me" by trying to induce a miscarriage during pregnancy. Winnicott's approach with her enabled her to go through "a terrible agony" and to feel by the end that she had been put together.

Like Balint, Mr. B. (1981) focused on how, Winnicott "let me be." He added, "That is the most exceptional thing he did."

In his writing about early development, Winnicott (1956, p. 303) notes that, "If the mother provides a good enough adaptation to need, the infant's own line of life is disturbed very little by reactions to impingement." "The basis for ego establishment," he explains, "is the sufficiency of 'going on being,' uncut by reactions to impingement." Winnicott sought to provide an environment in analysis that allowed for the patient's going on being.

Guntrip (1975, p. 152) recalled Winnicott speaking to this same issue of "going on being" during his treatment. Guntrip had collapsed at the age of 3 1/2 after his younger brother's death. "Your problem is that that illness of collapse was never resolved," Winnicott pointed out (according to Guntrip's recollection). "You had to keep yourself alive in spite of it. You can't take your ongoing being for granted. You have to work hard to keep yourself in existence. You're afraid to stop acting, talking or keeping awake." Winnicott explained that because Guntrip's mother could not save him or his brother, "You're bound to fear I can't keep you alive . . . . You can't feel that you are a going concern to me . . . . You know about 'being active' but not about 'just growing, just breathing' while you sleep, without your having to do anything about it."

### De-Emphasis on Interpretation

As Balint noted, Winnicott's de-emphasis on interpretation was a part of his letting her be. He made a number of comments about this topic in his writing.

In his most comprehensive statement, Winnicott (1971) begins by saying that he has come, in general, to use interpretations less and less:

[I]t 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 (p. 86).

He then goes on to note that he sees interpretation to be especially detrimental with certain patients, by which he means the patients for whom he developed his new approach to psychoanalysis, those who do not have neuroses:

It appals 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 (p. 86).

He concludes with a characteristically wry, Winnicottian comment about the reason why one might make interpretations at times:

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. We may or may not enable him or her to encompass what is known or become aware of it with acceptance (pp. 86–87).

In a talk, Winnicott (1989) gave an illustration of this same point, of how an interpretation might interrupt a patient's progress:

Today, this afternoon, a patient brought me a dream . . . and suddenly I saw ahead to a solution of where he was getting to, so I let him have my idea of where he was, and he was so dissatisfied that the dream he'd brought with its own meanings to it had been treated in this way. He was absolutely angry with me and absolutely hopeless and he said, "When will you ever learn?" If I was right, I'd taken away his opportunity to be creative, to bring it next time

and the time after; and if I was wrong I'd interrupted his reaching an important bit of understanding through this dream (pp. 582).

Dinnage (1981, October 27) described Winnicott as not using interpretations with her. "What I hate is when you say something and the therapist tells you, 'No, you didn't really mean that, you meant such and such.' Winnicott didn't seem to do any of that at all. Possibly he was interpreting, but it was done painlessly, if at all." Khan (1981, November 11), who was in analysis with Winnicott a number of years earlier than was Dinnage, said interpretation did not play a central role, but he gave an example of one time when Winnicott did venture an interpretation. Winnicott spoke of Khan's idealization of his father. Khan claimed he retorted, "Look, you're 5'5, and who was your father? My father was 6'5. He lived to the age of 93. He was one of the most powerful Rajas in British India. Stick to what you know about." According to Khan, Winnicott did not repeat his interpretation.

In addition to deemphasizing interpretation with Balint, Winnicott (Balint, 1981) advised her to do the same in her own work as an analyst. Once he said, "You might want to interpret some in the first year or two with a patient, but that is so you don't get bored." Another time he told her that analysts should make an interpretation only once per month—and that is just to show they are not omniscient (cf., Winnicott, 1962, p. 167).

Winnicott (1954) commented, in his principal article on regression, that, with a patient who went through an extensive regression in analysis, he made one interpretation about her "oral erotism and sadism in the transference," and that interpretation was a mistake because it was made "about six years too early" (p. 280). In a letter (Rodman, 1987, p. 62) he explained he did not mean he had made only one interpretation but rather just this one interpretation "of instinct in the transference." He pointed out that "the whole analysis has been carried along by correct interpretations each one of which is absolutely vital." As can be seen in this letter, when Winnicott spoke generally about interpretation, he was referring to classical interpretation aimed at making the unconscious conscious and linked to the transference and often to Freud's instinct theory. He increasingly eschewed those interpretations, but he carried out another kind of discourse that may or may not be referred to with the term, "interpretation."

Little's (1982, October 12) way of phrasing it was that Winnicott's typical comment "was not an 'interpretation,' but it has *interpretative effect*." She described how he would speak: "He could say 'Why do you always cry silently?'; 'That must have been awful (or fun, or exciting);' 'I really *hate* your mother;' 'You must have felt lost without X;' 'I'll tell you a story;' 'Do you know . . .'; 'You need somewhere to cry, to put the tears, pee, shit, and so forth.'"

In Little's previous analysis, Ella Sharpe, according to Little (1989) "managed to convey that although my mother might perhaps have made some small mistakes I really had nothing to complain of . . .". Winnicott, in contrast, told her "Your mother is unpredictable, chaotic, organizing (i.e., creating) chaos. She's like a jack-in-the-box, all over the place" (Little, 1982, October 12). Such comments, she noted, "summed up in a few words the senseless world of my life from early childhood to that very time, and the senselessness of much of my earlier analysis, and so made it possible for me to find sense—in him and in myself."

Much of the discourse, as described by Little, involved Winnicott's helping her understand how childhood experiences had led to her becoming who she was. With Sharpe, the emphasis had been on Oedipal interpretations. If Little felt negatively toward her mother, Sharpe would see her as having turned against her mother because of the Oedipal rivalry. Little, in general, was confused about her mother, not predominantly

negative, and her tendency was to see herself as the selfish, babyish child her mother had treated her as being. Winnicott helped Little see much more accurately what had happened in her childhood and how her mother's chaos had affected her and led to her developing an internal chaos along with anxieties about her very existence.

### Two Failures: The Vase Incident and Falling Asleep

All who underwent treatment with Winnicott agreed that he failed his patients at times and made mistakes; he was anything but a robotic, impersonal, perfect analyst. One undoubted failure involves Winnicott's reaction after Little, near the beginning of her analysis, shattered a vase of his. Here is Little's (1985) published account of the incident:

In one early session with D.W. I felt in utter despair of ever getting him to understand anything. I wandered round his room trying to find a way. I contemplated throwing myself out of the window, but felt that he would stop me. Then I thought of throwing out all his books, but finally I attacked and smashed a large vase filled with white lilac, and trampled on it. In a flash he was gone from the room, but he came back just before the end of the hour. Finding me clearing up the mess he said, "I might have expected you to do that [clear up? or smash?], but later." Next day an exact replica had replaced the vase and the lilac, and a few days later he explained that I had destroyed something that he valued. Neither of us ever referred to it again, which seems odd to me now, but I think that if it had happened later on he would probably have reacted differently. As it was, it felt as useless as my struggles with Miss Sharpe or my mother, and I forgot it until recently. Many years later, long after termination, when asking for advice about a very disturbed patient who hurt me knowingly and repeatedly, I spoke of having hurt him. He agreed that I had, but added that it had been "useful" (p. 20).

There are some additional details from communications I had with Little. She had no doubt in her mind that his leaving her alone in the room was a "mistake" (Little, 1981, November 1). Little had the impression that he could become enraged with a patient, as he mentions in his article, "Hate in the Countertransference" (Winnicott, 1947). "I think now," Little (1986) observed, "he rushed out of the room rather than kill me. I think he was extremely angry, and he had to deal with his own anger. It's all he could do to come back and see me off the premises." That, in essence, she said, is what he told her when she asked him, years later, about the incident.

Relational psychoanalyst Darlene Ehrenberg (2010) has looked at this incident and assumed that Winnicott thought it was enough that he had survived her aggression. She said she disagreed with him in that: "I believe that not only does destructiveness in the interaction have to be survived by both patient and analyst, but also that *destructiveness has to be dealt with straight on*" (p. 132).

In my view, Winnicott would have agreed with Ehrenberg. Indeed he often spoke of the importance of the analyst surviving, without retaliation, a patient's attacks (e.g., 1971, pp. 91–92). He also knew that more than survival is preferable. "The actual acting out in the analysis is only the beginning," Winnicott (1954) noted. "There must always follow a putting into words of the new bit of understanding" (p. 289). In the vase incident, I think, recognizing how enraged he was, he believed that he could not talk about the broken vase in a way that Little, who was so fragile at the beginning of analysis, would have been able to endure. In addition, I think that, by the time they could have discussed her destruction of the vase, he concluded there was no longer any benefit in doing so. No doubt, it would have been best for him not to have left the room after Little broke the vase and to have discussed her action calmly; however, he was incapable of behaving then in that way.

There is an area of failure of Winnicott's that deserves special discussion. One of the most unambiguous errors an analyst can make is to fall asleep during sessions. Three of the people I interviewed mentioned that Winnicott sometimes did just that. Surprisingly, all three claimed it did not significantly harm their treatment. Enid Balint similarly noted in an interview with Peter Rudnytsky (2000) that Winnicott fell asleep with her, and she too spoke of it as if it did not bother her. "He was hard and straight and really there," she commented. "Except when he didn't want to be, and then he just went to sleep" (p. 22).

"He would go to sleep," Little (1981, November 1) told me. "I would yell at him to wake up. But I understood; it was very boring to listen while I talked and talked." Little (1982) noted she would get angry because it felt as if she were being dropped, but then, undeterred, she would continue with the session.

Dinnage (1981, October 27) recalled one time Winnicott fell asleep, but she described the experience, unexpectedly, as "quite nice." She felt it meant he trusted her. During a session, after he had been asleep, he told Dinnage (1981, October 27) the following story, which she repeated in his words, as best she could:

Do you know what happened once during the war? There'd been a lot of bombing raids, and my patient came, and he said, "You look very tired." And I said, "I am pretty fagged out." And he said, "Why don't you go to sleep?" So I got on the couch and went to sleep. And he wandered around the room and looked at the books and so on. You know, it never made any difference. We just carried on like before.

Khan (1981, October 15) too had a comment on this topic: "These two Americans are attacking Winnicott. They say he falls asleep in sessions. He does, but it doesn't matter. He delivers the goods."

My view is that Winnicott's falling asleep was an undoubted shortcoming. It is likely that it sometimes had a negative effect on patients. His widow, Clare Winnicott (1982), tried to excuse it by writing me he did this "only during the last years of his life when he began to suffer from heart failure." But the testimony of Dinnage (who heard from Winnicott a story about his falling asleep during World War II) and Little (whose analysis with Winnicott started in 1949) suggests his falling asleep during sessions did not begin during the last years before his death in 1971. Yet I find Khan's argument convincing. Winnicott's occasional sleeping, while an error, was not a fatal error, as, despite his sleeping, he generally could provide what his patients needed.

### Creating a Holding Environment

What did it mean that Winnicott delivered the goods? Holding the patient was a fundamental factor. Speaking about treating the patients who are not neurotic, Winnicott (1963a) notes that the analyst should know about "the interpretations that might be made" but should avoid being "sidetracked" into doing what would be "inappropriate;" he means that one should avoid making interpretations with these patients. "The main need," he asserts, "is for an unclever ego-support, or a holding." "This 'holding,' like the task of the mother in infant-care, acknowledges tacitly the tendency of the patient to disintegrate, to cease to exist, to fall for ever" (p. 241).

In describing holding, Winnicott (1963a) noted that it "often takes the form of conveying in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced, or that is waiting to be experienced." "Occasionally, he added, "holding must take a physical form, but I think this is only because

there is a delay in the analyst's understanding which he can use for verbalizing what is afoot." He added that in taking care of a child with an earache "soothing words are of no use." "Probably there are times," he noted, "when a psychotic patient needs physical holding, but eventually it will be understanding and empathy that will be necessary" (p. 240).

I asked Milner, who, like Winnicott used holding effectively in her analytic work, to define holding for me. Milner (1981) replied:

It has something to do with attention. A wide focus. Not interpreting. Being there. Being supportive. Being able to take everything in, to encompass all the opposites. It can include physical holding, but it doesn't have to. I don't do physical holding myself, but Winnicott often did.

Little (1982) also provided me with her understanding of holding. She wrote it has both the literal meaning of physical holding and a more metaphorical meaning, as a description of the "mother's overall function." "Many patients," she noted, thinking of the parallel to babies, "need the bodily experience of being held firmly and consistently, not alternately clutched and let fall, nor being put in pram or cot with a feeding bottle popped up on the pillow. They need it because it is a fundamental experience which they never had in infancy."

She emphasized that holding requires strength and stamina, not so much because of the physical component but because of the emotional pressures. Winnicott's approach, Little (1982) wrote, "made great demands on him, demands he was willing to meet." These included "standing anxiety, guilt, pain, grief; knowing, and not knowing, not being able to do anything; standing what can't *be* stood, that is, *not being able to stand* something."

Little (1982) recalled the difficulties Winnicott experienced in his work with one suicidal patient. While the patient was talking about suicide, Winnicott "went through a long period of anxiety, and guilt, because he hated the patient for making him feel anxious and guilty." When Winnicott saw that the suicidal threat had become dangerous, he arranged for the patient's hospitalization. But the patient killed himself "unnecessarily, and for the wrong reason, as D. W. felt, because his instructions [regarding the hospitalization] had been ignored." After the patient's death, Winnicott experienced "fresh guilt and helplessness; he should have been able absolutely to prevent it; fury, with those who had failed to carry [out] his instructions, and, finally, a deep sense of loss of someone about whom he had cared intensely, and in whom he had invested so much feeling."

Near the end of his life, Winnicott talked with Khan about Alfred Flarsheim, a psychoanalyst from Chicago who struggled with severe depression and traveled periodically to London for treatment with Winnicott. "I can't help him," Winnicott said to Khan (1981, October 15). "If I were 10 years younger, I could hold him." Nine years after Winnicott's death, Flarsheim tragically committed suicide.

Any kind of physical touch is controversial in psychoanalysis. Probably with that in mind, Winnicott's widow, Clare Winnicott (1981), claimed he did not use physical holding with the exception of restraining a child who was out of control. Several of the people I interviewed contradicted her.

Little (1985) provided the most extensive description of her being held, physically and otherwise:

Literally, through many long hours he held my two hands clasped between his, almost like an umbilical cord, while I lay, often hidden beneath the blanket, silent, inert, withdrawn, in panic, rage or tears, asleep, and sometimes dreaming. Sometimes he would become drowsy, fall asleep and wake with a jerk, to which I would react with anger, terrified and feeling as if I had been hit . . . "Holding," of which "management" was always a part, meant taking full responsibility, supplying

whatever ego strength a patient could not find in himself, and withdrawing it gradually as the patient could take over on his own. In other words, providing the "facilitating environment" . . . , where it was safe to be (p. 21).

When I asked Mr. B. (1981) whether Winnicott used physical holding, he answered, "For Winnicott therapy was like the mother–infant relationship. Physical holding could be a part of this. If it was the thing to do, he would do it. He certainly did this with me."

Milner (1981), who worked closely with Winnicott, commented, "Winnicott did quite a lot of physical holding. There is a lot of controversy about this. It is like the story of the *Sorcerer's Apprentice*." She recounted the story. When the sorcerer is away, his apprentice tries to use powers like the sorcerer's to do the cleaning. At first he manages to make the broom clean by itself. But soon things get out of control. The broom goes wild. It divides. The broom knocks over furniture and breaks windows. Later, thinking back to what she had told me, Milner (1982) wrote, "Winnicott may have been able to use physical holding successfully. Maybe others try in a way that doesn't work."

Dinnage (1981, October 27) was one who said Winnicott never used physical holding with her. "But I do remember I was crying one time," she told me, "and he put his hands out and said, 'Cry on my hands.' But I was afraid to do that." As I was talking with her, I could sense that she was someone uncomfortable with physical contact, and, as she put it, "jumpy." I was struck by the sensitivity of Winnicott's gesture. Through the possibility of her crying into his hands, he offered a means of physical contact that avoided his touching her, and he made the offer in such a way that she could decline.

Dinnage (1981, October 27) said a therapist she saw before Winnicott would hug her and stroke her hair. She did not experience his behavior as being sexual, but nonetheless it made her uncomfortable. "Winnicott would never have pounced on somebody," she commented. "It was so different when he asked whether I wanted to cry on his hands. He never would have just grabbed me, as this other man did. The other man was trying to be very broadminded and modern, but to me it was really a shock and unpleasant. I think Winnicott just had a special gift."

Dinnage (1982, July 15) was cynical about the way the term, "holding," came to be used: "Anyone who's kind and friendly to a patient then congratulates himself on 'holding' him, and pins an extra medal on himself." "Holding," she went on, "might actually mean great efforts of intellect, and of suffering, and of attention, and of stamina. I know; I've been *un*-held by a large number [of other therapists]."

After the publication of Little's (1985) article on her analysis with Winnicott, "Winnicott Working in Areas Where Psychotic Anxieties Predominate: A Personal Record," there was much criticism, in the British psychoanalytic community, of Winnicott and also of her for writing the article. Khan (1985) wrote to her praising the article and her courage in writing it. He remarked, "What the analysts *envy most*, in their colleagues, as well as patients, is the capacity in *some*, to hold, and sustain, severe psychic states of disturbance, yet keep working, creatively."

### Adaptation to Need

In patients for whom Winnicott (1955–1956, pp. 296–297) developed his innovative way of conducting psychoanalysis, the key factor was what he called "a true self hidden, protected by a false self." "The false self," he explains, "may achieve a

deceptive false integrity." But "the false self cannot, however, experience life or feel real." In working with these patients, "the setting becomes more important than the interpretation." ("By setting," he explains, he means "the summation of all the details of management.")

Elsewhere Winnicott (cited in Khan, 1975, p. xxvii) explains that these patients need "phases of regression to dependence in the transference." This regression provides "experience of the full effect of adaptation to need that is in fact based on the analyst's (mother's) ability to identify with the patient (her baby)." In other words, he attempts to provide for the patient something analogous to what the young child receives from the good-enough mother. He goes on, "In the course of this kind of *experience* there is a sufficient quantity of being merged in with the analyst (mother) to enable the patient to live and to relate without the need for projective and introjective identificatory mechanisms." Along the same lines, Winnicott (1954, p. 298) concludes in another article, "*Good enough adaptation by the analyst* produces a result which is exactly that which is sought, namely, a shift in the patient of the main site of operation from a false to a true self." "Regression," Winnicott (1954, p. 289) notes, "reaches and provides a starting-place, what I would call a *place* from which to operate. The self is reached." He concludes, "What happens from here is felt as real."

On this topic more than anywhere else, we need concrete illustrations: What did it mean in practice for Winnicott to provide a suitable "setting" for the patient and to adapt to the patient's needs?

Guntrip (1975) described the physical setting in which Winnicott conducted analysis:

His consulting room was simple, restful in colors and furniture, unostentatious, carefully planned, so Mrs. Winnicott told me, by both of them, to make the patient feel at ease. I would knock and walk in, and presently Winnicott would stroll in with a cup of tea in his hand and a cheery "Hallo," and sit on a small wooden chair by the couch. I would sit on the couch sideways or lie down as I felt inclined, and change position freely according to how I felt or what I was saying. Always at the end, as I departed he held out his hand for a friendly handshake (p. 149).

Dinnage (1981, October 27) also had a vivid memory of the atmosphere of the consulting room. "He had a fuzzy, white Indian rug by the gas fire, and he would sit on the rug while he was talking, and his suit would get all covered with white. Sometimes I would bring a radio, and we would just listen to a concert." She added that her sessions were 1 1/2 hr in length: "He said, 'Fifty minutes is not good for you.' I think he was absolutely right. When I saw a therapist for 50 minutes, I never felt I had time to get into a session."

Winnicott's way of relating to her seemed to have an effect on her almost from the beginning of the analysis. At the time she was in her forties, and, since her divorce several years previously, she had "fled totally from men." "Within a few weeks of starting therapy," she recalled, "this great love affair of my life began. This guy was driving me back and put the car radio on very loud. And I suffer a bit from claustrophobia. And here I was in this little car, with a rather unknown man and the music on. But from the first time I was just kind of sitting there. I wasn't tense or getting out of the car." Her fear and distrust of people diminished well before there was any chance for an extensive exploration in her analysis of her life.

Mr. B. (1981) gave me a description that has some similarities to Dinnage's. "I could be silent with [Winnicott]. He also gave me long sessions. Often three hours. One of us might go to the toilet. Or go out for a walk. There was my feeling that this being with him would last."

His usual posture during sessions, according to Clare Winnicott (1982), was “[sitting] forward on a low straight chair with his elbows on his knees.” She added, “For a long time I could never understand why his trousers split across at the knees.”

Little provided the most detail. With her too he provided sessions lasting longer than the standard 50 min. “He saw quickly that I needed more than an hour. I always saw him for 1 1/2 hours. It took me a half hour to get started. Then I had an hour.” She further noted, “Winnicott never let the phone disturb him while he was with me. I liked to have the room dark during sessions. Maybe the blinds drawn, with little light” (Little, 1981, November 1).

After the session, Little (1981, November 1) often lay on the couch in the waiting room. “He understood that often a person isn’t ready to get on with the outside world right away. Sometimes I wasn’t fit to drive when I came. I might kill myself. I’d hand him my keys at the beginning of the session.” When he felt she was ready to drive, he would return her keys to her.

Little (1982) saw the longer session as part of Winnicott’s adaptation to need:

He could accept and adapt to a patient’s individual needs, “tailoring” his work to suit a deeply regressed patient. Such things as length of sessions—1 1/2–2 or even more hours; frequency of sessions—5, 6, or 7 days a week, or two sessions in a day sometimes, sitting in a dark room, beside the patient, not behind him; keeping silent and unmoving for long stretches of time, with nothing happening, and nothing to do; holding the patient’s hands clasped together between his own.

To Little (1982), the larger theme was Winnicott’s participating in a human relationship with the patient:

There was no doctrine, no “ritual” beyond what an individual patient needed (e.g., handshaking, helping on with coat, cup of coffee at session end). And above all no “mystical experience.” Humanness was all-important, and his nonsense and foibles contributed to it. (Why choose the Navy rather than Army or R.A.F? The uniform suited his blue eyes better!) . . . and he could enable a patient to laugh at him, and [he could] laugh at himself and laugh with him. So he could allow a patient to have an infancy and childhood of his own, such as he had not experienced before, and to grow.

Analytic sessions could contain anything, play, silence, reliving, “acting-in,” or “acting out,” teasing, mourning, and *all* feeling and its expression, whether by patient or analyst. Whatever the patient brought, which was sometimes a need for *him* to bring something.

Little’s emphasis on Winnicott’s humanness resonates with a comment Guntrip (1975, p. 153) says Winnicott once made to him: “We differ from Freud. He was for curing symptoms. We are concerned with living persons, whole living and loving.”

### The Capacity to Use the Object

Winnicott (1954, p. 287) says at times that the analyst’s holding of patients and the analyst’s adaptation to patients’ needs enable patients to experience “a new sense of self” and to undergo a “new progression of the individual processes which had stopped.” At other times, especially later in his career, he states that more is needed. “There are many patients,” Winnicott (1971, p. 94) asserts, “who need us to be able to give them a capacity to use us. This for them is the analytic task.” After “the full effect of adaptation to need,” Winnicott (1971) explains:

Then comes the painful process whereby the object is separated out from the subject, and the analyst becomes separated off and is placed outside the omnipotent control of the patient. The analyst's survival of the destructiveness that belongs to and follows this change enables a new thing to happen, which is the patient's *use* of the analyst, and the initiation of a new relationship based on cross-identifications (p. 137).

(A relationship based on cross-identifications is one in which an individual, seeing the other person as separate, is able to put oneself in that other person's shoes, to have empathy with the other, and the other person is also able to empathize with the individual.)

Winnicott's understanding here of how analysis works is based on his theory of development. He saw the infant as starting with object-relating—that is, a way of relating in which the mother is not seen as being a separate object nor visualized as being outside the infant's sense of omnipotence. The infant then moves to object-usage—that is, the position at which the mother is seen as separate and someone with whom interactions are possible. Object-usage becomes possible with the infant's "perception of the object as an external phenomenon, not as a projective entity, in fact recognition of [the object] as an entity in its own right" (Winnicott, 1971, p. 89). Similarly, with patients who have schizoid or borderline disorders, he saw them as often requiring the analyst's help in their moving from object-relating to object-usage.

In looking at that fundamental shift, Winnicott emphasized the role of the patient's destructive attacks and the analyst's survival of them without retaliation and without the analytic process being disrupted.

"What is it that may be enough for some of our patients to get well?" Winnicott (1963b, p. 258) asked. "In the end the patient uses the analyst's failures, often quite small ones . . . 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." In other words, for these patients the mother's failures took place during the stage of object-relating; the patients as babies could not understand or negotiate these failures but could only respond to them by unconsciously building up a protective false self. In analysis, these patients, after a considerable period of the analyst's adaptation to their needs, can encompass the analyst's failures. The patients can become angry or express hatred and the analyst is able to survive. They are able to suspend the false self; in Winnicott's phrase, they "hand" it over to the analyst. Winnicott is saying that a process that did not occur in early childhood can occur in analysis. When Winnicott (1954, p. 290) refers to "regression to dependence," he is speaking of this process whereby, within the transference, the patient hates the analyst and the analyst remains in contact with the patient, tolerates the hatred, and does not retaliate. I asked Little whether Winnicott provided something that could be considered "corrective emotional experience" and I added, "Those are almost dirty words in the United States." Little (1986) replied, "Well, I suppose that regression to dependence is a corrective experience. I don't see what else you can call it."

There is a short example, in Guntrip's account of his analysis, that is related to this process. Near the end of his analysis he resorted to "hard talking," which I take to mean blunt, no-nonsense speech, possibly tinged with anger. As Guntrip (1975, p. 153) remembered, Winnicott commented:

It's like you giving birth to a baby with my help. You gave me half an hour of concentrated talk, rich in content. I felt strained in listening and holding the situation for you. You had to know that I could stand your talking hard at me and my not being destroyed. I had to stand it while you were in labor being creative, not destructive, producing something rich in content.

You are talking about "object relating," "using the object" and finding you don't destroy it. I couldn't have made that interpretation five years ago.

The gist of Winnicott's comment is that he survived Guntrip's "talking hard at" him. In contrast, early in life Guntrip's experience was that his mother could not tolerate it when he expressed such vehemence.

Dinnage (1981, October 27) provided another example. After learning about Dinnage's history, Winnicott told her, "What you have to do is break down with somebody else there." A therapeutic regression developed. As part of it, she recalled, "I worked up some kind of quarrel with him. I would say, 'I hate you, and you're no good at analysis'—that kind of thing. And I did things like tearing up his letters." Winnicott, in Khan's (1971, p. 225) words, often allowed "maximal scope" for regression, as he did here. Dinnage said he accepted, even encouraged, her hatred. It seems he recognized that her expression of anger, and his survival of it, would be therapeutic for her. After one session, he wrote her a letter saying, as she paraphrased it, "I'm the worst person in the world. I've done everything possible to hurt you. I have destroyed your life. I have ruined your analysis." What his letter meant to Dinnage was, "I heard you last week when you said those things." Winnicott provided an atmosphere in which Dinnage had freedom to express her bitterest feelings and most deeply felt disappointments toward him, in the transference. She saw those feelings as analogous to what she would have felt toward her mother if she had been able to have her feelings in her childhood.

Reflecting on her earlier "ordinary" psychoanalysis with Sharpe, Little (1987, p. 10) noted, "Ordinary psychoanalysis was unsuccessful, and [with Winnicott] I needed deep regression, to the level of total dependence, from which I have been able to develop, albeit belatedly, to become something of a more real, balanced and mature person." She highlighted a particular experience of regression in her analysis with Winnicott. One summer she had trouble during his summer holiday. As the next summer approached, Winnicott told her that he wanted her to go into a mental hospital while he would be away. She reacted by trying to hit him. "He caught my wrists and held me, and was not hurt," recalled Little (1985, p. 32). His survival of her attack is significant. Little felt in childhood she never could express anger toward her mother.

One evening in the hospital, according to Little (1985, p. 32), "I was full up with anger. I let fly at my supper tray; I hurled the reading lamp and anything I could find across the room in an orgy of smashing." Though placed in seclusion that night and feeling paranoid, she recovered. "I . . . clung," she recalled, "to two things which later proved to be 'transitional objects,' a handkerchief which D.W. had given me, and a soft blue woolly scarf which I had liked and bought" (p. 32). These objects helped her, I would think, because she imbued them with meaning that associated them with Winnicott and with maternal soothing.

Although she was physically separated from Winnicott during her hospitalization, she saw her time there as a part of her analysis with him:

In my sessions with D.W. there had been "token" infant care; he always opened the door to me himself, each session wound up with coffee and biscuits, he saw to it that I was warm and comfortable, and provided tissues, and so forth. But here was the full "regression to dependence," an extension of what he had given me; and he kept in constant touch with the hospital and sent me postcards letting me know where he was (p. 33).

As Little (1985, p. 33) saw it, being in the hospital had a similarity to being in Winnicott's consulting room, where she had smashed his vase and he had left the

room. "His putting me in hospital was a repetition of his reaction to that earlier smashing, but this time the contact was not broken as it had been then, when he left me alone with the wreckage I had made." Within Winnicott's theoretical framework, the patient's destructiveness can be useful but only if the connection to the analyst and the analytic process survives the attacks (Winnicott, 1971, p. 90).

### Winnicott's Interactional Style

As seen in Little's comment about how Winnicott provided her with "token infant care," his approach was a vast distance from that of the traditional stance of psychoanalysts who present themselves as a blank slate on which patients can project anything. Several of Winnicott's patients described his way of interacting with them.

Mr. B. (1981) recalled what it felt like to have Winnicott focused on him and to receive his "undivided attention." "He was able to do that, like a mother."

Dinnage (1981, October 27) remembered feeling welcomed by him. "On a fine day," she said, "he would put his chair outside the front door, waiting for me to come, as it seemed to me. I'd come down the street, and he'd be waiting at the top of the steps." She described another time "when he was ill and confined to a room at the top of the house. He was looking out the window. These are the things that as a patient you remember. For me, his attitude is what really recounted."

My impression is that Winnicott typically expressed his embracing and his appreciation of a patient indirectly, as in his way of waiting for Dinnage's arrival. According to Guntrip, however, Winnicott directly told him about his positive feelings about him. Guntrip (1975) recalled that Winnicott said the following to him:

You too have a good breast. You've always been able to give more than take. I'm good for you but you're good for me. Doing your analysis is almost the most reassuring thing that happens to me. The chap before you makes me feel I'm no good at all. You don't have to be good for me. I don't need it and can cope without it, but in fact you are good for me (p. 153).

After hearing this comment, Guntrip (1975) felt, "Here at last I had a mother who could value her child, so that I could cope with what was to come" (p. 153). In other words, he felt that Winnicott valued him, as a mother might with a child but as Guntrip believed his mother had not with him.

Little (1982) noted:

He made this concern and caring quite apparent to patients who often found it surprising, never having experienced it before. This could not only reassure a patient who feared annihilation, but also increase his sense of being valued, and from being valued to being valuable, and so to value himself.

Little (1985, p. 22) emphasized Winnicott's in-touchness with his emotions. "He did not defend against his own feelings but could allow their full range and, on occasion, expression." "Without sentimentality," she went on, "he was able to feel about, with, and for his patient, entering into and sharing an experience in such a way that emotion which had had to be dammed up could be set free."

Little (1985) illustrated this aspect of Winnicott's behavior by noting how he reacted to her telling him of her mother's treatment of her when, as a child, she had a painful toothache:

Once, crying with toothache at the end of a long day which had been tiring for everyone, I was told, "Do stop crying, darling, you make everybody else miserable," and next morning, when the abscess had burst in the night and the pain was gone, "You see, it was all a fuss about nothing." And often, "Cheer up, darling! You'll soon be dead." This made him very angry. "I really *hate* your mother," he said. He was "shocked" when I told him how till the age of 10 and over I had to "rest" every afternoon in a darkened room with no toy or book, and was shamed when I had gnawed the candle by my bed until it had a waist and I could get small fragments of wax that I could chew and squeeze and mold (pp. 22-23).

His eyes filled with tears, Little (1981, November 1) recalled, when she spoke about her gnawing on the candle. "When I told him about the death of my earliest friend, a girl that I was friendly with," Little (1986) noted, "he put my hand up to his face so I could actually feel the tears."

One of the achievements of analysis, Winnicott (1958, p. 29) notes, is for the patient to be able to be comfortably silent in a session. "Perhaps it is here that the patient has been able to be alone for the first time." He compares the process in analysis with the process in early childhood. "The capacity to be alone depends on the existence of a good object in the psychic reality of the individual." He notes, "Maturity and the capacity to be alone impl[y] that the individual has had the chance through good-enough mothering to build up a belief in a benign environment" (1958, pp. 31-32). The implication is that, when treatment is optimal, patients internalize the analyst and thereby reach the point at which they experience a relative sense of security, trust, and groundedness.

Guntrip (1975, p. 152) was describing this process of internalization when he noted that Winnicott enabled him "to reach right back to *an ultimate good mother, and to find her recreated in him in the transference.*" He had been traumatized by his brother's death and by the loss of his aggrieved mother at that time.

Dinnage (1981, October 27) described the same process in more detail. She said that a focus of her analysis with Winnicott was "trying to make him last in my mind out beyond the consulting room." She brought to analysis a history of separations. While she was a child, her parents regularly took lengthy trips, sometimes for months, and left Dinnage and her brother behind. During World War II she was one of a substantial number of British children who were evacuated to Canada to live with people they had never met before. She had felt painfully alone while in Canada. During her analysis, Winnicott helped her to do what seemed to her to be "strange things." "For example," she recalled, "I would go out of the consulting room into Victoria Station and write a letter to him saying, 'You're still in mind,' and post it. Then I would go another mile toward home and write another letter saying, 'You're still in my mind.' I found it difficult," she added, "to believe that things were real."

Complementing Dinnage's description of her analysis with Winnicott is a glimpse of her analysis provided by Winnicott. Late in his life, Winnicott (1971, p. 20) decided to reprint his article on transitional phenomena and to add to it a section showing "where I feel that the theory I have formed for my own benefit in regard to transitional phenomena affects what I see and hear and what I do." The chapter was published in his posthumous book, *Playing and Reality*. In that added section, the patient whose analysis he describes is Dinnage. Dinnage (1981, October 27) recalled that when the book came out, she bought a copy and read it "with a kind of secret feeling, 'I wish I was in this book.' And then this weird thing happened." She said she came across, "tacked onto this quite important paper, a whole bit describing a session I'd had with him." "It was a pretty extraordinary experience to find that after his sudden traumatic death." Dinnage (1981, November 10) read over and discussed the section with me.

Winnicott (1971, p. 20) states that he presents the clinical material "to show how the sense of loss itself can become a way of integrating one's self-experience." He says he

chose this session because "it collects together various examples of the great variety that characterizes the vast area between objectivity and subjectivity." He is referring to the transitional area.

As we have seen, Dinnage's life was haunted by continual separations and losses. Winnicott (1971, p. 22) mentions that Dinnage experienced "the death of the mother when she is present"; in other words, her mother seemed absent even when she was there. And she also experienced her mother's "death when she is not able to reappear and therefore to come alive again." Winnicott (1971, p. 15) noted that the child can maintain "a memory or mental image of the mother" for a period of time, but, if the mother is absent too long, then "the memory or the internal representation fades." With the many absences Dinnage suffered in childhood, her internal representations were unstable. Such a difficulty, he noted, was rooted in "the time just before the child has built up the ability to bring people alive in the inner psychic reality apart from the reassurance of seeing, feeling, smelling."

In the session, Winnicott (1971) explains:

. . . my patient reached the position . . . that the only real thing is the gap; that is to say, the death or the absence or the amnesia . . . , and it turned out that the important communication for me to get was that there could be a blotting out, and that this blank could be the only fact and the only thing that was real. The amnesia is real, whereas what is forgotten has lost its reality (p. 22).

Winnicott (1971, p. 24) goes on to note that the two of them developed "an idea which was rather new from my point of view."

Here was the picture of a child and the child had transitional objects, and there were transitional phenomena that were evident, and all of these were symbolical of something and were real for the child; but gradually, or perhaps frequently for a little while, she had to *doubt the reality of the thing that they were symbolizing*. That is to say, if they were symbolical of her mother's devotion and reliability they remained real in themselves but what they stood for was not real. The mother's devotion and reliability were unreal (p. 24).

Winnicott (1971, p. 24) states that the patient, with all of her losses, came to the following formulation: "All I have got is what I have not got." Winnicott sees this stance as "a desperate attempt here to turn the negative into a last-ditch defense against the end of everything. The negative is the only positive."

In speaking with me, Dinnage (1981, November 10) confirmed that she had come to the idea of the importance of the "blank," the idea that "blank is form." She said the idea is similar to that of the Buddhist text, the "Heart Sutra." The message there is: "That which is form is emptiness, and that which is emptiness is form." She felt that Winnicott could understand her and could join her in her finding her way of making sense of her experience.

In the session, according to Winnicott (1971, p. 25), "we ended up with a bit of a game," a piece of play that involved Dinnage having a fantasy: "She was going on a railway journey to her holiday house and she said: 'Well I think you had better come with me, perhaps halfway.'" Her fantasy involved her dealing with separations, which were difficult for her. In the fantasy, she has Winnicott leave at a halfway station and return to London. She then, as Winnicott sees it, teases him about his maternal abilities and says, "And it will be very tiring, and there will be a lot of children and babies, and they will climb all over you, and they will probably be sick all over you, and serve you right." In my view, she plays with their separation as a way of maintaining contact with him, of keeping alive her representation of him.

In this session, we see Winnicott working, and understanding, in the area of transitional phenomena. Within that space, Dinnage, in close communication with Winnicott, imbues her experiences of separateness and loss with meaning, having to do with the reality of a blank or an absence. That is the essence of what goes on within the transitional area: extending personal meaning to one's experience or the objects in one's life. In this instance there is the unique twist that Dinnage gives meaning not to an object but to an absence or a blank. Dinnage also creates a transitional phenomenon, her fantasy of the trip with Winnicott, in which she keeps alive her connection with Winnicott, just what she had had difficulty doing with her mother. Winnicott participates in the transitional area by traveling half way with her and by receiving her communication.

### Conclusion

One time Dinnage (1981, October 27) told Winnicott he seemed to be a natural healer. He replied, with some embarrassment, "Yes, I do seem to have this gift somehow," and changed the subject. Winnicott's undoubted intuitive ability, along with his failure to write systematically—and with concrete illustrations—about how he conducted analysis might give the impression that he practiced "a random type of therapy," of which, as Little (1982) noted, "he is often accused." What this article shows is that Winnicott's way of conducting analysis was systematic, carefully thought out, and grounded in his understanding of child development. I found a close coordination between the principles of treatment he discussed in his work and the reports of those who were in analysis with him. There is, moreover, a large degree of agreement among these reports.

What is the essence of Winnicott's way of conducting analysis? In another article (Anderson, in press), written from a psychobiographical perspective, one topic I look at is Winnicott's own experience of being in analysis. He had two lengthy analyses, one with James Strachey, the other with Joan Riviere; both he deemed to be failures. I argue that he developed the form of treatment that would have helped him in ways that Strachey's classical approach and Riviere's Kleinian approach did not. Growing up with a false self—not the most extreme kind, but one nonetheless—Winnicott had a constant search for the life that feels real. The patients for whom he developed his form of psychoanalysis were those he saw as being imprisoned in a false self.

His goal was to provide a holding environment within which patients could relax their false-self protectiveness. He put aside interpretation, that is, interpretation of the classical kind that focused on the unconscious, and he participated with the patient in a joint effort to understand what had happened in childhood and what feelings, often buried or dissociated, were attached to the disappointments, traumas, and inadequate parenting that the patient had undergone. Through his humanness, his understanding, and his nonintrusiveness, he enabled patients, as more than one of them described it, "to be." Within that atmosphere, the true self can come out of hiding, and patients have a chance to resume their growth and to develop a life that they experience not as futile but vital.

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