Some six months before Dr Winnicott's death in January 1971, a group of young Anglican priests invited him to come to talk to them. He accepted, and in a casual exchange of conversation they told him that what they needed guidance about was how to differentiate between a person who seeks their help because he is sick and needs psychiatric treatment, and one who is capable of helping himself through talking with them. Telling this story to me, Winnicott said that he had been taken aback by the awesome simplicity of their question. He had paused a long while, thought and then replied:

‘If a person comes and talks to you and, listening to him, you feel he is boring you, then he is sick, and needs psychiatric treatment. But if he sustains your interest, no matter how grave his distress or conflict, then you can help him alright.’

I was deeply impressed by the wisdom of Winnicott's reply, and since then, whenever I see a person in consultation, this statement of his is never out of my mind.

Re-reading Winnicott's ‘Fragment of an Analysis’ has brought that question into an even sharper focus for me. We have two accounts of this patient from Winnicott, one which he recorded in his paper ‘Withdrawal and Regression’ (Winnicott 1954a, reproduced in the Appendix to this volume), and the other presented in ‘Fragment of an Analysis’, of which this is the definitive text.1 It is instructive to compare these accounts in their style, character and content.

For my argument it is important to distinguish between boring and boredom. The Oxford English Dictionary defines the verbal substantive boring as ‘the practice of annoying and wearying others’, and the noun boredom as ‘the state of being bored; tedium, ennui’. It is my hypothesis here that boring has the quality of the ‘anti-social tendency’ (Winnicott 1956) and implies a demand and a hopefulness, whereas boredom is an organised and defensive mood and a psychic structure. Similarly feeling bored is a normal state and

1 An earlier version was published in Giovacchini (1972).
different from boring. When I re-searched into Winnicott's writings for the antecedents of his idea that boring is a symptom of psychiatric sickness, I found that one can trace it, though in indirect and obverse ways, from his earliest writings.

Winnicott (1936) himself has told us that ‘careful history-taking has had a profound effect on my outlook….’ To witness his way of observing infants and children is often very revealing towards a true understanding of his later sophisticated psychoanalytical hypotheses. The cases presented in his first book, Clinical Notes on Disorders of Childhood (1931), already establish his distinctive style and sensibility as a clinician. He always observes the infant and a child as a whole person in his given caretaking environment. Two chapters from that first book have been republished in his collection of papers, Through Paediatrics to Psycho-Analysis (1975).

What stands out from his case-material in those chapters is how Winnicott singles out restlessness and fidgetiness in children for special observation. The fidgety child cannot process and master psychically, through playing, his excitement and anxiety. He turns them into behavioural ‘nuisances’, e.g. tics, fidgetiness, disorders of appetite, constipation etc, as appeal to the environment. This phase of Winnicott's clinical experience finds its first theoretical statement in his paper ‘The Manic Defence’ (1935). My purpose here will be to find out what are the psychodynamics of that psychic state which compel a person to be boring.

It is not an accident that, moving from his clinical data from paediatric work with children to analysis of adults, Winnicott should write his first serious analytic paper on manic defence, which is an intra-psychic way of dealing with anxieties that have their behavioural counterparts, fidgetiness and restlessness, which he had observed in children. Winnicott (1935) postulates that he has come ‘to compare external reality not so much with fantasy as with an inner reality’. This seemingly casual statement carries a vital shift in Winnicott's approach to psychic experience. Later he was to see in compulsive fantasying a negation of psychic reality: ‘fantasying remains an isolated phenomenon absorbing energy but not contributing – in to dreaming or to living’ (Winnicott 1971). Winnicott sees in manic defence an attempt to deny inner reality, a flight to external reality and an attempt to maintain ‘suspended animation’. He gives four clinical samples to make his point (Winnicott 1935). The first is of Billy, aged five. He had been referred for restlessness and inability to enjoy what he had acquired. In analysis, Billy's games were not playing but wild attacks. As the child's persecutory anxiety lessens, he begins to be able to use material for playing and expressing concern for the characters of his fantasy. The second, David (aged eight), an asocial child, came to analysis for being turned out of school on account of ‘sex and lavatory obsession’. In an early session the
child had remarked: ‘I hope I am not tiring you’, and Winnicott adds that ‘the aim to tire me out soon asserted itself’. But alongside there was in this child the need to save the analyst from exhaustion, and he provided Winnicott with compulsory rest periods. What became clear was ‘that it was he who was becoming exhausted’. One can see how clearly tiring and boring are related together, as techniques of coping with inner stress. The boring patient is trying to maintain omnipotent control over his inner reality by obsessional over-control of language and material. His narrative is a petrified space where nothing can happen.

Winnicott's next case of Charlotte (aged 30), who was clinically a depressive with suicidal fears, gives account of how the patient reported a stock dream: ‘she comes to a railway where there is a train, but the train never starts’. After she had settled into her analysis she had a dream where the train started. Winnicott interprets: ‘In simple language, trains which start to move are liable to accidents.’ The need in manic defence is to freeze all possibility of anything happening. This is why I am extending Winnicott's concept to postulate that the patient who compels boring narrative on us is not letting language and metaphor elaborate or change his experience. He creates a space of discourse where both he and the analyst are paralysed by the technique of the narrative as well as its monotonous and repetitive contents.

The fourth case is of an obsessional patient, Mathilda (aged 39). When, in a session (from which Winnicott reports), she had brought a Polyfoto of herself (48 images) for him to look at, Winnicott had discovered in it the patient's wish for ‘a denial of her deadness by looking and seeing’, and how the patient had ‘felt it more real for me to see her photo (a 48th of her) than for me to see her herself. The analytic situation (which she has spent four years proclaiming to be the reality for her) now seemed to her for the first time to be unreal, or at least a narcissistic relationship, a relationship to the analyst that is valuable to her chiefly for her own relief, a taking without giving, a relationship with her own internal objects. She remembered that a day or two before she had suddenly thought, “how awful to be really oneself, how terribly lonely”.’

In these clinical vignettes we already have the essentials of Winnicott's approach to the patient. Here we can already see him questioning the authenticity for the patient of what he or she produces or presents in the analytic situation and relationship. From this I would conclude that that which is boring is inherently inauthentic, both for the patient and the analyst. And yet we have to learn to tolerate this counterfeit discourse in order to help the patient. Freud (1895), in the very first case where he totally abandoned hypnotic techniques and worked exclusively with free-association method, had encountered this ‘boring factor’, and remarked:

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- 3 -

‘The story which Fräulein Elisabeth told of her illness was a wearisome one….’ (my italics).

In the context the next important paper by Winnicott is ‘Reparation in Respect of Mother's Organized Defence against Depression’ (1948a). Here Winnicott introduced his concept of ‘a false reparation’, which derives from ‘the patient's identification with the mother and the dominating
factor is not the patient's own guilt but the mother's organized defence against depression and unconscious guilt.’ Winnicott's work here was an attempt to find some answer to a climate of acrid debate in the British Psycho-Analytical Society during the previous decade between Melanie Klein and her followers who placed total emphasis on unconscious fantasies and others (chiefly Edward Glover) who considered some of the fantasies attributed to the patient as the subjective creations of the analysts themselves. Winnicott tried to show how much the mother's mood can impinge upon a young child's growing psychic reality and dislocate it from finding its own character.

We shall see how later Winnicott was to extend this hypothesis into his concepts of the true and false self organization of personality. A more dramatic clinical example of the intrusive effect of mother on a child Winnicott gives in his paper: ‘Mother's Madness appearing in the Clinical Material as an Ego-alien Factor’ (1972).

Already in his paper ‘Primitive Emotional Development’ (1945) Winnicott had given a succinct account of how he saw the infant-mother relationship:

‘In terms of baby and mother's breast (I am not claiming that the breast is essential as a vehicle of mother-love) the baby has instinctual urges and predatory ideas. The mother has a breast and the power to produce milk, and the idea that she would like to be attacked by a hungry baby. These two phenomena do not come into relation with each other till the mother and child live an experience together. The mother being mature and physically able has to be the one with tolerance and understanding, so that it is she who produces a situation that may with luck result in the first tie the infant makes with an external object, an object that is external to the self from the infant's point of view.

‘I think of the process as if two lines came from opposite directions, liable to come near each other. If they overlap there is a moment of illusion – a bit of experience which the infant can take as either his hallucination or a thing belonging to external reality.’

In this paper we have in rudimentary form all of Winnicott's later concepts, e.g. holding, transitional object and dependence. It was on the primary model of mother – infant relationship that Winnicott was to elaborate the nature and character of transference and the role of the analytic setting. He was to emphasise one process, ‘that of the individual's contact with shared reality, and the development of this from the start of the infant's life.’ (Winnicott 1948). Winnicott sees a hazard for the analyst in such an undertaking:

‘…many treatments of schizoid types of adolescent fail because they are planned on a basis that ignores the child's ability to “think up” – in a way, to create – an analyst, a role into which the real analyst can try to fit himself’ (Winnicott 1948).
In his paper ‘Birth Memories, Birth Trauma, and Anxiety’ (1949) Winnicott states that ‘there is evidence that the personal birth experience is significant, and is held as memory material’ but he insists that ‘there is no such thing as treatment by the analysis of the birth trauma alone’. He recounts certain episodes from the analysis of a female patient Miss H. (aged 50), and concludes: ‘In the very close and detailed observation of one case I have been able to satisfy myself that the patient was able to bring to the analytic hour, under certain very specialized conditions, a regression of part of the self to an intra-uterine state.’ What is even more significant is Winnicott's statement: ‘It seems to me that it is in relation to the border-line of intolerable reaction phases that the intellect begins to work as something distinct from the psyche.’ It was this differentiation of precocious intellectual functioning in reaction to impingements that was to lead Winnicott to see in fantasying a pathological mental functioning that is a negation of psychic reality, and of which a certain type of compulsive free-association is the symptom in analytic process. Some vicissitudes of this type of developmental distortion of mental function Winnicott discusses in his paper ‘Mind and its Relation to the Psyche-Soma’ (1949a). The need in some patients ‘to be relieved of the mind activity’ in order to refine their psycho-somatic wholeness of being is seen in their demand for ECT.

In his paper ‘Anxiety Associated with Insecurity’ (1952) Winnicott spells out three main types of anxiety resulting from failure in technique of infant-care:

‘unintegration, becoming a feeling of disintegration; lack of relationship of psyche to soma, becoming a sense of depersonalization; also the feeling that the centre of gravity of consciousness transfers from the kernel to the shell, from the individual to the care, the technique.’

This memorization of the technique that fails I consider to constitute the essence of the technique of the patient who is boring. Such patients twist and abuse the analytic process we offer them to impose upon it an arid technique of relating (through discourse in the adult situation) of which

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they have been the victim in childhood. Behind it, as Winnicott (1952) points out, there is an ungraspable fear of madness in them:

‘There is a state of affairs in which the fear is of a madness, that is to say a fear of a lack of anxiety at regression to an unintegrated state, to absence of a sense of living in the body, etc. The fear is that there will be no anxiety, that is to say, that there will be a regression, from which there may be no return.’

The tyrannical repetitiveness of the boring patient's narrative congeals this latent ‘madness’ into an interminable verbiage.

The clinical means for dealing with such highly organized mental habits Winnicott discusses in his paper ‘Metapsychological and Clinical Aspects of Regression within the Psycho-Analytical Set-up’ (1954c). Essential for Winnicott is the issue of classification and choice of case. He distinguishes
three types of cases. First are those who can operate as whole persons and whose difficulties are in
terms of interpersonal relations. The second are those in whom wholeness of personality is
precariously held. Here analytic work relates to the developmental stage of concern (cf Winnicott
1963). The survival of the analyst Winnicott considers the dynamic factor in the treatment of these
patients (cf Winnicott 1963). The third are those whose analysis must deal with the very beginnings
of personality formation as a differentiating entity in itself. Here the emphasis is on management,
and the clinical handling of regression to dependence in the analytic situation.

For Winnicott ‘the word regression simply means the reverse of progress’ and ‘there cannot be a
simple reversal of progress’. There has to be an ego organization which enables regression to occur.
Hence the capacity to regress is the result of favourable environmental care in infancy and
childhood. It is this positive aspect of infant-care in these patients that, according to Winnicott,
egeners in them a belief in the possibility of the correction of the original failure, through
specialized (clinical) environmental provision, towards new forward emotional development.

In the care and treatment of these patients the emphasis shifts to the quality of the analytic situation.
One passage from Winnicott states (1954c) it lucidly:

‘It is proper to speak of the patient's wishes, the wish (for instance) to be quiet. With the regressed
patient the word wish is incorrect; instead we use the word need. If a regressed patient needs quiet,
then without it nothing can be done at all. If the need is not met the result is not anger, only a
reproduction of the environmental failure situation which stopped the processes of self growth. The
individual's capacity

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The regressed patient is near to a reliving of dream and memory situations; an acting out of a dream
may be the way the patient discovers what is urgent, and talking about what was acted out follows
the action but cannot precede it.’

The understanding and management of regressive states, explicit or cloaked, were the primary
concern of Winnicott's clinical work. Freud and other analysts had established the ubiquitous
presence of regression in all psychiatric illnesses and in the transference relationship. Their
emphasis had been largely on regression to more primitive stages of libido development, with
Corresponding fantasies and wishes. Winnicott added to this the emphasis on the element of need in
regressive phenomena and states.

That said, let us return to the present clinical material. I am deeply indebted and grateful to Mrs
Clare Winnicott for making available to me the total notes that Winnicott kept on this case.
As Winnicott indicates in his brief introductory remarks to the material presented here, this patient had been in analysis with him earlier, during the war. In fact there are three separate sets of extensive notes from three stages of the two analyses of this patient with Winnicott.

From the beginning of the analysis Winnicott had decided to take notes. The first set of notes belong to the first analysis and are titled ‘Fragment from an analysis’. Winnicott had written it up in a draft form but never published it. What he says there is so revealing that I shall quote his introduction to those notes directly from the typescript:

‘In this paper I wish to make use of some rather unusual clinical material.

‘It is difficult to report analytical material. First, there is the immensity of the task of remembering an hour's work and then of writing it down. Second, there is the quantity of material and the difficulty there must be in choosing from it. Third, there is the special difficulty analysts seem to find in recording what they themselves said.

Here, however, all these three difficulties are to some extent overcome. My patient spoke slowly and deliberately, and what he said could be easily recorded; I chose a special moment to make records, one which I knew would be decisive for the analysis; and I actually wrote down what I said whether I was pleased or ashamed of it.

In the analysis of a young man of 19 a stage was reached which was

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obviously likely to prove critical. After a long and steady pull the patient and I were reaching the top of a hill and seeing more and more, partly because, as we reached the top, the work itself became less arduous. We were to cash in on a year's analysis and, in order to learn as much as possible from what was happening, I took down several hours almost verbatim. I think I can say in this case the patient did not know that I was adopting this unusual procedure. Of course I would not have done it if it would have really mattered a great deal had the patient discovered it.

Without describing the whole case, I would say that in this analysis the striking feature was the ease with which the patient was in touch with his feelings towards the objects of his inner world and the ease with which he told me about these as long as he felt that I was in this inner world with him. Going with this, as might be expected, was a stubborn resistance in the form of a dissociation in the patient's personality, so that he in analysis had very little relation to himself in the external world.

The fragment of analysis which I wish to report marks the period of the breakdown of this resistance.

This analysis was a straightforward one. It had that momentum of its own which is so nice for both analyst and patient. In spite of big interruptions because of the fact that the patient's university was evacuated from London, the patient had acted as if he knew he needed help, believed that he could
get help. Moreover, he did not behave as if he felt – as some patients do – that the analysis would be
snatched away at any moment if he did not hurry.

I might describe how his analysis started because it throws light on the character of the transference.
One day the patient's mother rang me up and said that she was in analysis with So-and-so and she
had a son aged 19 who wished for analysis for himself. Would I see him? I replied Yes, send him at
5 o'clock tomorrow. At 5 o'clock the next day the boy came into my room, lay down on the couch
and started analysis exactly as he would do a year or two later. In other words, analysis for him
meant something which he already believed in. As he left the room he went up to my bookcase and
saw two books which he said were in the bookshelves at his home. In this and in every way he
showed that he placed in my chair someone who already belonged to his inner world, and it is
roughly speaking true to say that I remained an object of his inner world until the moment which I
am about to describe in the first of the analytic hours which I took down verbatim.

In other words, up to this point, which was roughly speaking a year, interrupted by evacuation
during terms, the patient's relation to me was an extremely artificial one unless one understands just
what was

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happening. The material was rich and the work done considerable, but it was impossible to reach,
for instance, the dynamics of the Oedipus situation. The period of transition was in fact heralded by
the patient's first recognition of the reality of jealousy in the external world in the form of a casual
statement that he had read something about a thing called the Oedipus complex and didn't hold with
it. During this first half of analysis I made no attempt to force the situation because I knew, from the
type of the transference, that it would be absolutely futile to do so, and also because the analysis
was steadily progressing so that one could expect eventually the development which would throw
light on what might be called a resistance or a negative therapeutic reaction.

Going ahead of the clinical material, in order to give the reader something to catch on to, I would
say that the vital change in the analysis came with the analysis of the patient's fear of completing
analysis. There is a number of ways in which anxiety is produced by the idea of completion of a job,
and with this patient the accent was on one way, namely the disappearance of the hallucinated
breast or subjective good external object at the moment of gratification and cessation of desire.

For him this was worse than aggression towards the love object – it annihilated it.

Up to this point in the analysis I had been an internalized person, and analysis had gone along
swimmingly in its own way and within its own limitations. After it, however, the analysis and the
patient's life changed. In analysis he became able to relate me to external phenomena, and to lose
his serious dissociation, so that he now brought external matters into the associations. At home he
started a new relation to his mother, one based on observation of her real self; and the patient
changed from a self-satisfied, self-centred, lazy young man who dressed in abnormal garments and
affected a beard, into a man who wanted a job and who eventually took and is holding a responsible war job in a factory. Moreover, the Oedipus situation, which had previously been unreal to him, and which had not been able to be brought into the analysis, now became real to him in the classical manner.’

The clinical notes that follow give a verbatim account from five sessions towards the very end of that analysis, which had lasted roughly two years. It had ended because the patient had become able to take a war job in an engineering firm. Two themes preoccupy the patient: fear of ending analysis and it becoming a ‘complete’ experience; and the confusion of this

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with the patient's dread of ‘the violently hostile content of satisfaction at the end of the meal, which means annihilation of desire and annihilation of subjective breast followed by hostility to persisting objective breast’ (Winnicott's interpretation to the patient in one of the sessions). The acute fear of satisfaction from a good, or rather ideal, feed features persistently in the material of the five sessions. One interpretation of Winnicott to the patient in this context is worth quoting here:

‘Satisfaction means something more important to you than the blotting out of the breast. It means the loss of desire for it, and at that moment you do not know whether you will ever recover that desire; and in so far as the breast is a subjective phenomenon this means that you have no knowledge that the breast will come again. You are at the mercy of your instincts and your capacity for instinctual gratification, unless you recognize someone with breasts as objective phenomenon and dependence.’

The first analysis had lasted nearly two years, with long holiday breaks. The patient, who had been considered suffering from a schizophrenic-type illness, had made good recovery.

Some eight years later Winnicott wrote spontaneously to the patient's mother:

‘You may be surprised to get a letter from me, but I would very much like a note from you about B.

I know that on the whole it is not a very good idea to get into touch with past patients, and for that reason I am writing to you and not to B himself. Nevertheless one's work becomes much more interesting if one can follow up cases, and as I remember B's analysis very clearly I have often intended to ask you to let me know about him.

I hope you are well and that he is well.’

The mother wrote back eagerly, and Winnicott asked her to see him. I quote his account of the interview with the mother:
‘Mrs X came to see me at my request, although she was pleased to do this and to give me a report on the family. It was interesting to note that a great change had come over her description of B’s home life. In the intervening years Mrs X has herself had a long analysis and she now describes herself as having been very ill.

In the first interview with me she had said that if any child had ever had a perfect childhood it was B. It was in her own analysis that she discovered that her perfection as a mother had a symptomatic quality. She simply had to be perfect, and this allowed for no flexibility and

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was derived from very great anxiety in herself. This unexpected bit of news completely confirms the main conclusion drawn from the analysis of B, since what we unexpectedly found there was that in reliving the very early breast-feeding experience he felt completely annihilated at the end of a feed and for this reason he had been unable to let himself go in any feeding experience. The subsequent development of this boy may be said to have been satisfactory. I would say that the only non-satisfactory feature from my point of view is that he is a communist, but of course, it is not necessary that membership of this party should be a symptom of illness. In my opinion this is one relic of his need to defend himself against his mother, who in spite of herself rather obviously dislikes these political views of her son.

The main feature of the recovery of this man is that he acknowledges nothing at all from his analysis. I always recognised it to be extremely important that no claim for recognition or gratitude whatever should be made. A perfect analysis would be just as difficult for him as a perfect management of infancy and would annihilate him. His only possible way is for him to have changed as a result of it, and I now regret having once allowed myself to stop him in the street to ask him how he was, although this apparently did no harm.

His return to analysis will almost certainly come through the fact that he has now become a medical student, and it is quite likely that he will come round eventually to wanting to be an analyst. He would probably be the last person to know this, and it is a point to remember that in his own analysis which must precede his becoming an analyst he will have to arrive at some consciousness of the way in which he was helped in his own analysis. If he is not to be an analyst there is no reason at all why he should ever know.

After the end of the analysis he changed and, after changing from an introverted man with indeterminate sex and a big liability to be turned over into homosexuality by a seduction, he suddenly went into an engineering works where he was soon managing other men. He was able to change his job when he found that he had to, but he always knew that engineering was not his interest, it being simply the kind of life he had to lead because of the war. He was not really well enough to join the army, and in any case one would think that his roots in Great Britain are not deep enough for him to want to die for the country. At the end of the war he was able to reconsider his position and he decided to be a doctor. He is now married and will soon have a child. An important
part of his management came through the mother's recovery in her own analysis so that she was able to turn him out of her own house. In other words, the analysis in this man did not go far enough to enable him to get away from his mother with her as well as she was at the time when he was under treatment. The benefit of the double analysis is clear. His younger sister is fairly straightforward, married, with a family, but his older sister is a schizophrenic having analysis and at present being cared for in a hospital. B had retained his very great interest in music and he seems to have found a wife who can understand him and can take the place of his mother without being like the mother. In other words, it seems as if he has not had to find another ill mother, although to some extent he has found someone rather like his mother is now she has recovered through having had a long analysis.’

Nothing seems to happen for another four years, though from some notes it appears that Winnicott kept in touch with the mother spasmodically during this period. The next we hear of this patient is when he goes voluntarily to a hospital specialising in treatment of neuroses and is an in-patient there. The psychiatrist in charge of him had got in touch with Winnicott and informed him that the patient, after qualifying in medicine, had a breakdown and was admitted to that hospital. The patient himself was resistant to returning to Winnicott for further analysis. A note scribbled in pencil around this time by Winnicott states: ‘I heard that the patient was in a certain hospital and I got in touch with the doctors there, knowing that the time must have come for the continuation of the analysis. I had kept in touch with the mother. The patient had no capacity to come and look for me.’ From the existing correspondence it seems that around this time the mother also rang Winnicott and came to see him. Two days after this consultation, the mother wrote to Winnicott: ‘I have just spoken to B and gave him your address and phone number – I do hope he comes to see you and is able to start analysis soon.’ The reason the mother had to give her son Winnicott's address was that since the first analysis Winnicott had moved to a new address. The patient started the analysis a week later, while still an in-patient at the hospital. So the second analysis starts some thirteen years after the end of the first. A note in pencil by Winnicott about the beginning of the new analysis is very telling:

‘When the analysis restarted it was hardly true to say that he came to see me. Rather it seemed that an observer of life came and talked with me in a rather well arranged rhetoric. We sometimes talked of the patient. Gradually I would say we have become two nursery maids talking about a boy (the patient), and in time the nursery maid brought the boy – even the baby – to see me. I got a few glimpses of a real child.’
At first the patient came five times a week but some four months after starting analysis he was able to leave the hospital and take up a medical appointment, which necessitated his coming three times only. This analysis lasted just over two years.

There are two sets of notes from this second analysis. The first set consists of notes Winnicott wrote retrospectively about the on-going analysis, and they cover, by and large, the first sixteen months of the analysis. From the end of this phase of analysis Winnicott abstracted five episodes which he has reported in his paper ‘Withdrawal and Regression’ (1954a). Then there is a gap of three months, and after that Winnicott keeps a verbatim record of the sessions of the last six months of analysis, which are published here.

To end the account of Winnicott's dealings with this patient it only remains to be stated that Winnicott again wrote to the patient, from his own initiative, some fourteen years after the termination of his second analysis. I quote the letter:

‘You may be surprised to hear from me: indeed you may have forgotten me. But the fact is that I would very much like to hear a word from you about yourself, your work, your family. I'm at the age at which one looks back and wonders.

I send you my very good wishes.’

The patient answered promptly with a very long letter, giving news of himself and his family, and telling Winnicott of the sad death of his mother after a distressing and long illness. He had fared well in his own work and life. Winnicott replied to him:

‘I was so very pleased to get your reply to my letter. Thank you for the trouble you took going over things. I am sorry your mother had an uncomfortable end. She was indeed a personality.

I am impressed by the way you have used your life instead of perpetual psychotherapy. Perhaps that's what life is. (I might write to you again one day.)’

In his Preface to the Second Edition of The Gay Science in 1886, Nietzsche wrote:

‘This book may need more than one preface, and in the end there will still remain room for doubt whether anyone who had never lived through similar experiences could be brought closer to the experience of this book by means of prefaces.’

I feel a similar sentiment faced with the task of introducing Winnicott's extraordinary verbatim record of the last six months of the long-stretched
analysis of his patient. The virtue of Winnicott's clinical narrative rests in the fact that its drift is as undeclared as its psychodynamics are open-ended. Even though in his brief introductory remarks Winnicott frames his account in the context of the Depressive Position, the actual events of the 'subtle interplay' (p. 173 below) between him and the patient are untrammeled by any intrusive theoretical presuppositions. This should not be mistaken for naiveté on Winnicott's part. He was a clinician endowed with a complex sensibility, and over the years he had actualized in himself a mercurial intellectuality that informed all his clinical work. However, he had also cultivated in himself the generous discipline of letting the patient's psychic reality find its mood and character in the analytic space. Therefore each of us, who reads his narrative, will turn it into a discourse according to the needs and bias of his own sensibility.

I shall discuss it under three headings:

a) the patient's way of relating to himself;

b) the patient's use of Winnicott;

c) Winnicott's style of presenting and dosing himself to this patient.

Winnicott was an indefatigable note-taker of his clinical encounters. Where he found the energy and the time is a mystery. All the same, he did not take such extensive notes on all his patients. Something about the manner in which this patient presented himself and took hold of the clinical space struck Winnicott from the very beginning. In his first draft notes from the start of the analysis, quoted above, one hears Winnicott tell that he was impressed by 'the ease with which the patient was in touch with his feelings towards the objects of his inner world', and that the patient had little difficulty in verbalizing these thoughts, even though ponderously. When the patient starts his second analysis, Winnicott notes: 'Rather it seemed that an observer of life came and talked with me.…We sometimes talked of the patient.' This curious and calculated stance of the patient persists right through to the end. One could argue that for this patient nothing existed but his thoughts, and that his basic attitude was: I refuse, therefore I am. It is this refusal and these thoughts that are the contents of the perpetual chatter that goes on in his head, and which Winnicott (1971) was to call fantasying. It is this mentation that isolates his subjective self from others, and even from his own reflective self-awareness. Towards the outside world he is merely reactive. Towards his true self, if one may use that phrase, he has only a protective attitude. He can never reach it and live from it. Hence his complaints of lack of spontaneity and initiative. What established this irrevocable dissociation in him Winnicott attributes to the 'ideal' feeding experiences in infancy that robbed the patient of all initiative from need and desire. Instinctual urgency of hunger or lust push one towards the object.

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- 14 -

That is the one risk he cannot take. Hence he lived in the oubliette of that objectless space, which constitutes le terrain interne, of his mentation and self-observation. In it every experience is
represented by thoughts, but no experience or person is internalized. The patient himself remarks: ‘chatter is talking to no person’ (p. 143 below).

From the very beginning Winnicott was aware that the whole manner of talking and relating in this patient inherently carried a negative therapeutic reaction. The patient gives his own diagnosis: ‘I never became human. I have missed it’ (p. 96) and ‘To sum up, my own problem is how to find a struggle that never was’ (p. 165). Winnicott was not daunted by this. Nor did he set out to cure it. He allowed for its functioning as the necessary condition for this patient to exist in life. Because this patient rarely does more than exist. Furthermore, once Winnicott realised that the withdrawn affable mentation of this patient was not hostile in intent towards him, the analyst, he was challenged by the paradox of this patient's total acceptance of the clinical situation and space, with a parallel refusal of inter-personal relating and to initiate any play from spontaneous impulse. I advisedly use the word paradox. To have seen it in conflictual terms of ambivalence would have been a false oversimplification. It is through sustaining this paradox for some thirteen years of relating to this patient (one must not forget that for Winnicott this analysis lasted thirteen years and after; Winnicott had kept the patient alive in his memory all that time) that Winnicott was able to witness how this patient relates to himself and what is the character of that self-relating. It was boring-ness, not boredom! Boredom is a static, inert psychic mood. Boring-ness is an active existential stance, maintained through incessant mentation. Hence the eerie and mellow fatigue that we find in this patient, and which so readily enables him to shift levels of consciousness at any threat or prospect of true encounter with Winnicott, and drift into sleep.

This ‘couch-sleep’ provided this patient the truest experiences of himself, and this couch-sleep is a secret space to which even his dreams yield no clues. What monumental capacity Winnicott had to contain unknowing. He lets it all happen. The patient frets: ‘The thing is to wake up….I would like to wake up, that is, get up, go away’ (p. 168). But that he'll never achieve. He shall stay in the oubliette of his mentation. Hence he can have no aims. Where there is no route, there is no aim. When the patient raised ‘the vague problem of aim’ (p. 169), Winnicott promptly reminds him that he couldn't even come to Winnicott for his second analysis, and adds: ‘I had more or less to go and look for you’ (p. 170). At best this patient could only reach a point where he can be the isolated surround of his True Self, but cannot risk to live from it. Hence he bores himself with his techniques of self-care and self-cure all life long.

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When Winnicott had decided to frame this material in terms of the Depressive Position, he had good reasons to do so. The Depressive Position connotes an intra-psychic state, entailing specific affective capacities and other ego-functions. It is not an accident, perhaps, that soon after writing the first account of this patient's analysis in his paper ‘Withdrawal and Regression’ (1954a), the next paper by Winnicott should be ‘The Depressive Position in Normal Emotional Development’ (1954b). For Winnicott the Depressive Position constitutes an achievement in emotional development. The crucial passages in Winnicott's argument are:
‘The child (or adult) who has reached that capacity for interpersonal relationships which characterizes the toddler stage in health, and for whom ordinary analysis of the infinite variations of triangular human relationships is feasible, has passed through and beyond the depressive position. On the other hand, the child (or adult) who is chiefly concerned with the innate problems of personality integration and with the initiation of a relationship with environment is not yet at the depressive position in personal development.

In terms of environment; the toddler is in a family situation, working out an instinctual life in interpersonal relationships, and the baby is being held by a mother who adapts to ego needs; in between the two is the infant or small child arriving at the depressive position, being held by the mother, but more than that, being held over a phase of living. It will be noted that a time factor has entered, and the mother holds a situation so that the infant has the chance to work through the consequences of instinctual experiences; as we shall see, the working through is quite comparable to the digestive process, and is comparably complex.

The mother holds the situation, and does so over and over again, and at a critical period in the baby's life. The consequence is that something can be done about something. The mother's technique enables the infant's co-existing love and hate to be come sorted out and interrelated and gradually brought under control from within in a way that is healthy.’

The essential concepts for the understanding of this patient's use of Winnicott are in the phrases ‘the mother holds a situation’ and ‘the mother's technique’. If one examines carefully this patient's transference relationship, one feature stands out remarkably: the diligence with which he observes Winnicott's technique of analysing and takes it into his language immediately. All the way he refuses and negates the objective object Winnicott, in order to isolate Winnicott's technique of analysing and make it his own. What he leaves to Winnicott is the holding of the clinical

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- 16 -

situation and space. Furthermore, language provides this patient with all the barriers he needs to keep Winnicott distanced. Whenever the clinical process edges him towards mutuality, he falls asleep. His verbal ‘demands’ for physical contact are merely another ruse of his mind precociously to usurp an emergent need and/or wish in order to hand it over to language, where they then stay petrified and inert. Winnicott reassures him on this count: ‘I would say that a correct interpretation that is well-timed is a physical contact of a kind’ (p. 160). Winnicott senses all the way how precarious is the inner protective shield of this patient. Any accidental influx of actualized excitement in a physical mutuality of tenderness or concern could easily have played havoc with the perpetual gamesmanship of this man's mental apparatus. So Winnicott stays in the area of deliberate language as the exclusive mode of usage by this patient. Hence the patient never reaches his capacity for playing. It remains a nostalgic possibility in his thoughts. Winnicott is profoundly aware of the constrictions this patient has to live with. He tells the patient that he is ‘cluttered up with reparation capacity’ (p. 29), and this carries an ominous threat for this patient because ‘satisfaction annihilates the object for him’ (p. 30). Given these limits, the patient could use
Winnicott in a very specialized and distant way only. His basic use of Winnicott is to find a personalized space where he can spread out his thoughts and what he has observed of his experiences, and tentatively allow for interaction between them. But even here sleep is both his refuge and his only experience of dependence. Winnicott interprets after one of his sleeps: ‘You had a need then to be held with someone else in charge while you slept’ (p. 162). The persistent use that this patient makes of Winnicott is that of a certain reticence in Winnicott. The patient knows Winnicott knows more of him that he ever interprets. This is one shared secret between them. The other is Winnicott's note-taking.

Now I come to the last issue I wish to discuss: Winnicott's presentation and dosage of himself to this patient. In his paper, ‘Delinquency as a Sign of Hope’ (1973), discussing the anti-social tendency in a child who may steal a fountain pen from some shop Winnicott postulates:

‘…it is not the object that was being sought, and in any case the child is looking for the capacity to find, not for an object’ (author's italics).

I believe Winnicott sensed from the very beginning that this patient was searching to find a capacity in himself and not a relationship with an object. And this decided Winnicott to set a specific tenor to his relationship with this patient. Like the patient, he too became partially an observer of the clinical process. In him it took the form of taking notes. In another paper, ‘The Mother – Infant Experience of Mutuality’ (1970), discussing the experience

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of mutuality Winnicott states: ‘This mutuality belongs to the mother's capacity to adapt to the baby's needs’, and he elaborates it in terms of the clinical process as follows:

‘Analysts with a rigid analytic morality that does not allow touch miss a great deal of that which is now being described. One thing they never know, for instance, is that the analyst makes a little twitch whenever he or she goes to sleep for a moment or even wanders over in the mind (as may well happen) to some fantasy of his or her own. This twitch is the equivalent of a failure to hold in terms of mother and baby. The mind has dropped the patient.’

I believe that one other function the note-taking served for Winnicott was to keep him awake and aware during the patient's long pauses or lapses into sleep, and even during the assault of the patient's organized dense rhetoric in the sessions, which foreclosed mutuality by its very method. The printed narrative lends a somewhat false momentum to the verbal exchange between the patient and his analyst. The calculated idiom with which this patient manufactured his narrative was inordinately boring and the patient is aware of it. Somewhere, quite unconsciously, Winnicott drew upon his vast experience of doodling with children in consultation and used the space of the paper to doodle notes. His way of scribbling notes during the session comes much nearer to doodling than writing. He scrawled all over the paper, in all directions and sometimes upside down. Thus he himself stayed alive in somatic attention and his mind never ‘dropped’ the patient. Such patients
provoke a very uncanny sort of hate-response in the counter-transference which compels the analyst to intrude with interpretations to ease the tension generated or to lapse into a silence that is more inert and boring than the patient's narrative.

Winnicott also creates a secret space in the area of note-taking that matches the patient's secret space in couch-sleep. Thus both are safe with each other, and survive each other. Each is aware of the other's secret and lives with it, without questioning it.

The lessons for all clinicians who read this clinical narrative are many indeed. Perhaps the most important one is that one must not try to cure a patient beyond his need and his psychic resources to sustain and live from that cure.

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- 18 -

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