PSYCHOANALYTIC COLLISIONS

Second Edition

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MUTUAL IDEALIZATIONS AND THE DISAVOWED

I turn now to the dynamics of mutual idealizations within the analytic dyad and their role in therapeutic collapse. The notion that we might be involved in being idealized by our patients—or in idealizing them—collides with our professional ideal. Yet we analysts are vulnerable to participating with our patient in establishing and maintaining jointly held illusions. While those illusions most often take shape around the patient’s vision of us, at times this process tilts in the other direction: we idealize our patient more than the reverse. Here, I illustrate idealization’s coconstructed edge—and the collisions it can create—by examining Winnicott’s treatment of Masud Khan and Harry Guntrip.

In my psychoanalytic world, nearly everyone loved to love Winnicott.1 We were enchanted by his charming quirkiness and inspired by his capacity to function within the maternal metaphor—to repair. Winnicott’s writings evoked a vision of affective responsivity; his brilliant yet intuitive capacity for knowing invited the hope that unmet needs would finally be met, that we could be fully known. Winnicott came to represent the archetypal maternal analyst: loving, wise, always there. He provided us with a professional model, indeed an ideal, toward which to strive.

In Chapter 8 I describe how an idealized holding illusion that initially deepened analytic process ruptured, giving way to its underbelly—denigration. I came to recognize that I had unconsciously participated with my patient Robin in a shared idealization—one in which I both accepted her vision of me and mirrored it in an implicit idealization of her. In the process, I minimized both the power of her dissociative defenses and the limits of my own therapeutic potential.

I’m convinced that nearly all analysts are vulnerable to encouraging and enacting idealizations; these are processes that deserve study and exploration rather than censure. But when our own participation in mutual idealizations is revealed, we tend to judge ourselves harshly. Distressed, even appalled by our failure to meet the professional ideal, we feel ashamed, anxious, defective. Responding to disillusionment with self-condemnation or defensive denial, we close down, rather than opening up self-reflectivity.

We need to find an exit from this kind of splitting, to humanize our experience as analysts vulnerable to the vicissitudes of emotional states that include idealizations. It’s in this spirit that I return to Winnicott’s work with Khan and Guntrip, to his statements about idealization (1954a/1975) and to Guntrip’s (1996) description of his (idealized) treatment experience with Winnicott. A window into Winnicott’s relationships with these famous patients provides us with another perspective on analytic idealizations. But this project isn’t without risk. Winnicott has embodied a cherished professional ideal to many of us; in the process of illuminating my theme, I tread on that ideal and run the risk of being accused of “Winnicott bashing.”

Nothing could be further from my intent. It’s my hope that this chapter will be read not as an attack but as an illustration of a shadow analytic phenomenon, that we can explore Winnicott’s involvement with his patients without enacting the malignant underbelly of our idealization, that of denigration.

This project began with an immersion in Winnicott’s unpublished correspondence,2 the biographies of Khan and Winnicott (Goldman, 1993; Hopkins, 1998, 2006; Rodman, 2003; Willoughby, 2005) and consultations with Linda Hopkins regarding Khan’s unpublished Work Books.3 I use these materials to muse about how these treatment relationships illustrate the analyst’s vulnerability to processes of idealization and their relational dimension.

In my view, Winnicott’s need both to be idealized and to idealize can be identified in his work with Khan and Guntrip. In the case of Khan, the interpretation of Khan’s provocative narcissism with Winnicott’s more graceful variety (Goldman, 2002) shaped the treatment relationship. It became dominated by a mutually constructed but asymmetrical idealization, tilted in the direction of Winnicott’s more intense and unshaded admiration of Khan. In contrast, Guntrip’s relationship with Winnicott involved a shared idealization organized around Guntrip’s very positive maternal transference to Winnicott. Winnicott responded with reciprocally appreciative and loving feelings, creating a relatively symmetrical idealization. Before illustrating these dynamics, I detour into the nature of idealization in psychoanalytic work.

Idealization and illusion in psychoanalytic process

Idealization and illusion embody hope and foreclose analytic process. On one level, both are opposed by the very nature of psychoanalysis, which aims to dismantle encrusted, rigid belief systems that defensively deny or negate “reality.” We work to open up and expand our patients’ capacity to deal with what is, and in this sense, we oppose idealization by virtue of our analytic stance (e.g., Freud, 1914a; Rycroft, 1955; Sullivan, 1972; Fromm, 1991). Yet psychoanalytic ritual itself (Hoffman, 1996), especially its asymmetrical shape and the pretense of authoritative objectivity it invites (Renik, 1995), lends a degree of idealization to this endeavor. We’re supposed to “know”;

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we are, in Lacan’s (1978) terms, “le sujet supposé savoir,” and this is an intrinsic aspect of the transference, to be worked through but rarely evaded.

Much of this literature focuses on those intrapsychic conflicts that contribute to excessive idealization. Rooted in primary narcissism, idealization is classically viewed as a defense that negates envy, ambivalence, or rage (Freud, 1914a). Klein (1946) linked idealization to hallucination; the object is split and the good breast’s attributes are exaggerated in an attempt to control persecutory fear. Kernberg (1975) and Grotstein (1981) use this line of thinking to describe idealizations’ function in protecting the analyst from disavowed aggression, while Chasseguet-Smirgel (1974, 1976) notes that idealizations reflect primitive narcissism or perversion.

When used rigidly or excessively, idealizations of the analyst have a pathological edge. We find ourselves depicted as extraordinary—perfectly attuned, brilliant, bountiful, resilient, the “best” in our institute or city. At times, patients’ fantasies about us extend beyond the realm of our analytic capacity to our perfect personal lives, perfect children/spouse, home, and so on.

Although these kinds of idealizations appear to be directed outward, they implicitly embody self-deprecating feelings on the patient’s part; in comparison to the analyst, she’s inadequate, naive or childlike. “I’m nothing compared to you.” “You know me better than I will ever know myself.” “You have everything I need.” The patient renders herself inferior, unknowing, or undesirable in the presence of an omniscient and all-powerful analyst; mutuality is sacrificed in order to sustain a liaison (sometimes sexually charged) with the analyst (Aron, 1991, 1999; Burke, 1992; Caper, 1992; Ghent, 1992; Benjamin, 1994b, 1995; Renik, 1995; Gerson, 1996; Hoffman, 1996; Cooper, 2000a, 2000b; Davies, 2003).

Such illusions can have consequences that extend beyond the analytic situation—disrupting or destroying other intimate relationships, freezing a masochistic identification, or inviting sexual boundary violations.

A singular focus on the problematic of idealization, however, overlooks its positive dimensions. For the connection to a powerful, apparently perfect analyst is sometimes vitally sustaining. These visions can help establish a protected treatment space, encourage forward therapeutic movement, support a new identification, or strengthen the sense of self (Balint, 1968; Milner, 1969; Winnicott, 1971; Gedo, 1975; Eigen, 1980, 1993; Chused, 1987; Fossage, 1990; Bacal, 1995; Benjamin, 1995; Guntrip, 1996). As Kohut (1971, 1977) noted, idealizations serve a crucial developmental function in childhood and are central to work with narcissistically vulnerable patients.

Illusions are core in imaginative play and creativity, including the play of psychoanalysis (Winnicott, 1945, 1951, 1958; Loewald, 1975; Eigen, 1980). While rigid illusions of perfection are intrinsically fragile and vulnerable to collapse, more porous idealizations can open up creative possibility. If lightly engaged, idealized fantasies about the analyst, the patient, or the limitless possibility inherent in psychoanalytic process can support the work with altogether negating self-doubt, opening the realm of the whimsical and paradoxical (Ghent, 1992). Here, the desired coexists with more complex aspects of the actual; the patient tolerates ambiguity and uncertainty, moving beyond the presses of the moment into interior space (Slochower, 1966c, 20).

Our willingness to accept, rather than interpret or reject an idealization invite a fuller articulation of fantasy life. But for this space to be sustained, we must maintain contact with, yet bracket our own conflicted response being valorized; in so doing, we allow the dyad to move in and out of idealization rather than either foreclosing that space or altogether becoming embedded in it.

If idealizations sometimes fortify the patient’s therapeutic experience, they serve a similar purpose for the analyst? When we find reassurance and hope in patients’ visions, we tend to subtly (if unconsciously) encourage them. An expanded sense of therapeutic potential helps us counter self-doubt by supporting our emotional resilience and access to creative process. But for all of us, we analysts respond in various ways—negative or positive—to being idealized. Based both on our theory and personal process, we may resist the failure of recognition inherent in a patient’s idealization response to our pleasure in being idealized with discomfort, feeling in guilt, shame, or conflict about being thus viewed.

Idealizations exist in many forms and disguises. At their most overt, they are near caricatures of ourselves that reside at considerable distance from actuality. Yet when we reject the heroic analytic archetype, another kind of idealization may well be concealed beneath the vision of a vulnerable, imperfect analyst. This is a partial silhouette of the former that valorizes the analyst as an anti-hero, able to tolerate being utterly human and imperfect with conflict or anxiety. An idealized vision of a very different sort, the hierarchical, egalitarian analyst eschews idealizations.

“Unlike analysts of . . . school, I don’t need to be perfect.” This notio deeply human, nondefensive analyst has come to represent, in so many respects, an alternate vision, a sort of “analytic noir” idealization. It is, in a useful antidote to the excesses of analytic rigidity and certainty that more room for our failures. Yet a different kind of self-idealization can under it and obscure its dynamics: by idealizing our capacity to be vulnerable, obfuscate both our resistances (to being so fully seen) and the anxieties (at the potential exposure) that can underlie it.

Whatever their particular color, transient idealizations have clear therapeutic efficacy than those that are fixed and rigidly held. These are entirely objective criteria, however. How strong an idealization is excess? How long should it be allowed to remain unquestioned? Our assessment inevitably be colored by the theory we hold and the location of idealiz (as therapeutic or problematic) within it. And since an idealized relations is asymmetrical one, our feelings about our own authority are likely to
intertwined with our feelings about being idealized (see Friedman, 2007). Renik (2007) actively advocates working toward an egalitarian position that counters idealizations of our “superior” knowledge and authority, while others (e.g., Lander, 2007) underscore the temporary safety inherent in the patient’s idealization.

Those who emphasize holding or containing are more likely to find value in idealizations than those who locate therapeutic action in other arenas, for example, in sustained interpretation (e.g. of split-off hostility) or mutuality (Aron, 1991). Yet our theoretical allegiances are themselves shaped or at least reinforced by our dynamically informed personal style (Crastnopol, 1999). Some of us prefer to remain more or less “covered” and may unconsciously (or consciously) welcome, even prolong a patient’s idealization because of its self-enhancing effects or the protection against exposure it affords. Others respond with unease to the sense of being unseen or misconstrued; here, a need for recognition may lead us to quickly disrupt an idealizing transference and introduce our subjectivity into the mix.

Winnicott’s belief in the therapeutic value of regression to dependence—in the treatment of schizoid and psychotic patients especially encouraged idealizations organized around maternal themes. His patients Margaret Little (1990) and Harry Guntrip (1996) describe Winnicott as enormously empathic, sensitive, able to meet urgent, unarticulated needs. They believed that it was crucial to the success of their analyses that Winnicott allowed these maternal transferences to unfold naturally, without interference. Even Khan, who was often dismissive of Winnicott, spoke movingly about the therapeutic impact of Winnicott’s capacity to be “still” with him:

I did succeed at three occasions to sink into my Self . . . All these three occasions were physical . . . He was in my chair seated and I had got off the couch and buried my head into the side of his coat. I can still hear his heart and watch beating. All else was still . . . and I was at peace. And D.W. never interpreted those three occasions. He had enabled me to reach to that point.

(MK, WB, May 3, 1971)

Khan palpably evokes Winnicott’s impressive capacity for containment, his willingness to “be” the maternal object (and to break traditional rules to do so). Like Little’s (1990) description of Winnicott’s tolerance for, and capacity to meet, her vulnerability and dependence, Khan depicts Winnicott as calmly present. Not surprisingly, these are “one person” characterizations; Winnicott is the object of idealization more than a participant in its construction. We’re left to speculate about his emotional response to being idealized and his role in inviting, sustaining, or countering his patients’ therapeutic visions.

Whose illusion is it anyway?

On one level, all analysts love being loved. Being admired provides a welcome antidote to the feeling that we’re lousy analysts, that we don’t know what we’re doing, that we do it badly. There are probably times when we all rely on our patient’s admiration, inviting an unconscious mutual pact: “I’ll love you if you’ll love me.” As the needs of patient and analyst converge, the dyad constructs a vision of therapeutic safety, constancy, of the analyst’s curative power (Modell, 1975; Teicholz, 1999). Describing her work with an idealizing patient, O’Shaughnessy (1992) suggests that “under pressure from the patient, the analyst may unwittingly turn the analysis into a refuge from disturbance—i.e. an enclave” (p. 610). O’Shaughnessy is implying that the analyst participates in the maintenance of an excessively protected treatment space that excludes the negative. Within this safe but narrow space, patient and analyst tacitly buffer disruptive elements, tilting the treatment relationship in the direction of synchrony and reassurance.

I’m suggesting that analytic idealizations are often jointly constructed, shaped by patient and analyst’s personal attributes and needs. When we attribute illusions exclusively to our patients (e.g. Klein, 1940; Sullivan, 1972; Kernberg, 1984; Grunberger and Chasseguet-Smirgel, 1986), we obscure our own vulnerability to negating the space between the actual and the ideal, between what’s wished for and what is. And, as a result, our participation in this process tends to operate silently beneath the therapeutic surface, remaining implicit and unexamined.

At times, we do more than tacitly encourage a patient’s idealization; we embrace a “golden view” of the treatment process. Our need to believe in the possibility of psychoanalytic transformation leads us to seek out a sustaining background of safety (Sandler, 1992), to counter self-doubt or anxiety about our therapeutic efficacy, to find evidence that we’ve met our professional ideal. Self-affirmation becomes lodged in an idealized version of ourselves—in our capacity for penetrating insight, authenticity, affective attunement, playfulness, emotional openness, or neutrality and evenly hovering attentiveness. This jointly held idealization helps us garner a sense of value, authority, or omniscience, countering the self-doubt and uncertainty intrinsic to the work.

These are guilty pleasures, however, for the professional ideal largely precludes our attempt to derive narcissistic gratification from our patients. We aren’t supposed to want to be admired. We may even locate our capacity to invite and work with patients’ anger and other negative affect states at the center of analytic process: if we interfere with the emergent negative transference, we fail to do our job. And then there’s the nagging awareness that we don’t quite measure up to our patient’s idealized vision. Discomfort, even shame, may follow, pushing us to directly counter that idealization (“Do you really think I am so perfect? Well, I’m not . . .”) or, alternatively, to embrace it as an antidote to our “bad analyst feeling” (Epstein, 1987).
Perhaps the most veiled underbelly of analytic idealizations organizes around our tendency to valorize our patient. On one hand, the professional ideal pulls strongly against this reversal of ordinary analytic asymmetry; on the other, awareness of our own lacks, whatever their particulars, can be both painful and powerful. It’s inevitable that some of our patients will be more accomplished, creative, rich, or intelligent than we (Gedo, 1975); they may have more emotional resilience, a greater capacity to love and be loved, or perhaps better luck. Of course, the recognition of differences doesn’t necessarily reflect idealization; we may note all this without allowing that awareness to shade into a more globally positive assessment. Gedo (1981) states this with some humor: “One wonders what purpose is served by elaborately avoiding truths about the skills, wisdom, or beauty of people who are manifestly competent, wise, or beautiful” (p. 106n.).

Still, these apparently “objectively admirable” traits are anything but: they’re complexly informed by the patient’s need to be admired, our need to admire, and by our feelings of inadequacy, longing, envy, and so on.

Ordinarily, our idealization resides at a more accessible, multilayered, and conflicted level than our patient’s. We’ve been trained to track countertransference phenomena, to struggle with our feelings rather than simply enacting them. However, this is another ideal; there are moments when our response to a patient is so powerful that it forecloses self-examination and creates a reverse asymmetry.

When idealizations are shared by patient and analyst they’re especially likely to become thick and impenetrable. A powerful, mutual investment in excluding the discordant is embraced by the dyad, creating a nonelastic, rigid illusion. “We’re the perfect analytic couple.” “We’ll get past the obstacles that impeded my (your) previous treatment.” “I can provide precisely what you needed and lacked.” As the dyad becomes embedded in an asymmetrical enactment, the treatment gradually freezes and therapeutic action derails. I turn now to this dynamic as it seems to have played out between Winnicott and Khan.

**Winnicott, Khan, and the British society**

The therapeutic efficacy of Winnicott’s analysis of Masud Khan has been widely debated (cf. Rodman, 2003; Willoughby, 2005; Goldman, 2006; Hopkins, 2006). Did Winnicott help Khan by providing essential emotional support or was the relationship destructively collusive? There’s evidence supporting both sides of this debate; neither is my focus here, however. I’m instead interested in exploring how the dynamic of shared and asymmetrical idealizations played out between Winnicott and Khan. In my view, this therapeutic relationship was characterized by a coconstructed idealization, tilted in the direction of Winnicott’s more consistent admiration for Khan. Khan sometimes idealized his analyst, but that idealization alternated with competitive and disdainful feelings. The treatment relationship was characterized by excess (Stein, 2006) and an absence of reflectivity that invited a collision with actuality. It erupted into public space in 2001 when Wynne Godley, a former patient of Khan’s, published a description of his experience in analysis with Khan in the London Review of Books (Godley, 2001).

In his essay Godley revealed that Khan had engaged in multiple incidents of professional misbehavior with Godley and other patients. Although Godley’s exposé was primarily aimed at Khan, it also implicated Winnicott; both became the object of considerable critique within the British Society and abroad.  

Winnicott’s relationship with Khan, complex from the outset, involved both an analytic and professional connection. Winnicott referred patients (including Godley) to Khan as early as the mid-fifties (Hopkins, 1998, 2006) and in 1953, only two years into Khan’s analysis, they coauthored a book review. In years to come, Khan would help Winnicott edit many professional papers. Winnicott referred him patients and recommended Khan (and another patient, Margaret Little) for teaching positions (these referrals continued into the mid-1960s despite Khan’s increasingly egregious acting out; Hopkins, 2006). Godley’s report, in concert with biographical data (Rodman, 2003; Willoughby, 2005; Hopkins, 2006), make clear that although Winnicott knew about Khan’s socializing with Godley, Winnicott didn’t intervene to stop Khan until Godley asked him for help directly.

In addressing Winnicott’s apparent failure to take a stand with Khan, Hopkins (1998, 2006), Milner (reported by Sandler, 2004), and Willoughby (2005), all suggest that Winnicott pacified Khan because he was unable to handle Khan’s aggression, fearing the attack that would have come his way were he to have taken Khan on. Hopkins (1998) uses the well-known “vase” incident with Margaret Little to support her thesis that Winnicott couldn’t sustain object usage (i.e., a belief in the object’s capacity to survive attack).

The recent discovery of Winnicott’s diaries appears to confirm that Khan was formally in analysis with Winnicott for at most four years (from 1951 until 1955, not 1966 as previously reported, e.g., by Hopkins, 2006). While this puts to rest many of the accusations of explicit professional boundary violations on Winnicott’s part, the dynamics of his therapeutic relationship to Khan in those post-analytic years remain open to question. Did Winnicott, whom Khan describes as having continued to provide “coverage” for Khan until the mid-1960s, ever stop functioning as Khan’s symbolic analyst? Didn’t the “coverage” Khan describes represent an ongoing, albeit attenuated analytic relationship? Khan didn’t follow his brief formal analysis with Winnicott by a second treatment (Hopkins, 2006), and Khan himself refers to a long (15-year) analysis with Winnicott, suggesting that he continued to think of Winnicott as his analyst long after their formal sessions ceased: “In some 15 years of analytic relationship with DWW I did succeed at three points or occasions to sink into my Self… “ (MK, WB, June 28, 1978).
Indeed, even in 1971, many years after his analysis ended, Khan refers to the “care and coverage” he had received from Winnicott “over the past 20 years”:

One of the most valuable contributions of D.W.W.’s long protective care and coverage over the past 20 years of my growth and development as a person has been that he has changed a catastrophic threat of loss of object into separation anxiety.

(Cited in J. Cooper, 1993, p. 21)

I offer some thoughts about the role of mutual idealization in this relationship, but with a caveat: these are speculations rather than certainties. We can’t get inside this treatment or fully parse either man’s experience of the other; the prodigious biographical work on both men hasn’t yielded an entirely consistent understanding of Winnicott or Khan’s dynamics. And since even the unpublished materials (Winnicott’s letters and Khan’s Work Books) themselves were written to be read, they can’t be viewed as a veridical reflection either of fact or of Winnicott or Khan’s experience.

It’s unclear, for example, whether Winnicott’s admiration for Khan made it difficult for him to recognize, or in any case directly address, Khan’s extraordinary acting out. Or did Winnicott see all this but deliberately choose to adapt to Khan’s needs, having concluded that Khan couldn’t be helped analytically? Perhaps Winnicott’s personal and extra-analytic engagement with Khan actually helped Khan contact and work through unmet needs. Goldman (2006) suggests that Winnicott may have helped Khan avert a yet more catastrophic outcome and contributed to Khan’s psychological deterioration, while Sandler (2004) believes that Winnicott’s relationship with Khan was “collusive and pervasive,” driven primarily by Winnicott’s psychic issues.

Psychoanalytic theory can be used to rationalize our clinical interventions and professional breaches; this is true whether what’s at issue is standard technique or breaks from it. In my view, our theory and our personhood represent interpenetrating threads, each of which informs the other. I thus don’t believe that it’s possible to parse the role of Winnicott’s theoretical position from either his more dynamically driven beliefs about treatment or his emotional investment in, and personal reactions to, Khan.

Winnicott had a deep commitment to the legitimacy of meeting need (rather than desire) in work with very vulnerable patients; his paper on the antisocial tendency (1956), for example, underscores the role of deprivation (the loss of something good) embodied in theft. He argued fervently for the therapeutic efficacy of a reliable (holding) setting that met the child’s (and patient’s) needs and withstood acting out.

Was Winnicott persuaded that Khan was what Freud (1916) called an “exception,” to whom the rules didn’t apply (because of Khan’s early experiences of deprivation)? Or did the two jointly construct a pact organized around the positive, an enclave of idealization that excluded or obfuscated Winnicott’s more complex feelings about his analysand?

Analytic self-idealizations, whether based more in fantasy or in real experiences of clinical success, easily lend themselves to overuse, even to misuse. Winnicott’s ideas about early deprivation and the need for a maternal holding analyst seem to reflect aspects of his personhood, perhaps an idealization of his reparative capacity and the curative power of his emotional responsivity; both visions sideline Winnicott’s own vulnerability and need as well as his failure to withstand destruction (in line with Hopkins’s 1998, critique). On one level, Khan needed Winnicott (as his analyst and mentor); on another, Winnicott needed Khan (as an editor, collaborator, perhaps admirer?). I wonder whether the latter need found its way into a treatment dynamic wherein Winnicott became more the supplicant than the analyst.

Khan, a self-proclaimed Pakistani prince, very likely was viewed with both fascination and (racially based) suspicion by Winnicott and other British Society members. Khan was exotic, royal, and remarkably well read; Winnicott relied on him as an editor. Khan’s sexuality and flamboyance stand in striking contrast to Winnicott’s more self-effacing, asexual presentation. Did Winnicott sense or fear that he lacked those attributes (overt sexuality, exotic background, even intellectual prowess)? Did he struggle with envy and competitiveness toward his analysand? Did Khan become the son (and father) for whom he longed?

We’re on speculative, not certain ground here, but whatever its underlying dynamics, the evidence regarding Winnicott’s idealization of Khan seems clear. I quote from Godley’s (2001) description of a conversation he overheard between the two: “When Winnicott rang up I could clearly hear both sides of the conversation. Winnicott spoke respectfully to Khan, for instance about a paper which he had recently published. ‘I learned a great deal from it,’ Winnicott said deferentially.”

Godley, commenting on Sandler’s (2004) paper on boundary violations, explicitly suggests that Winnicott was “in thrall” to Khan (p. 42). There certainly is a quality of self-effacement in many of Winnicott’s letters and about Khan. In one such letter, Winnicott (1959) recommends Khan for what appears to be a teaching position, describing his own intellectual capacities as inferior:

May I make a suggestion which there is no need for you to follow at all. I believe that Masud Khan, with a little practice, would be really very good at the sort of thing that you are suggesting I should do for the group; in fact I think he would be very much better at it than I would be, because he has the power to conceptualise whereas I always seem to think in terms of the child I saw last week. I thought I would just put this suggestion into your mind, partly because I would personally like to see Masud Khan used in this sort of way.
And in a letter directly to Khan, Winnicott (1962) goes out of his way to compliment his examanalyst:

I want you to know that I find a real contribution in this paper . . . .
I think that this idea is not absolutely new but the way you have brought it out has really helped me in my work. You say that sometimes my concepts have helped you and I want to let you know when the traffic is the other way round.

Is this mere British politesse, or is Winnicott enacting a reverse asymmetry as he underscores the mutual aspects of his professional relationship with Khan? Does he attempt to rebalance Khan’s idealization of him while also expressing his own idealization of Khan?

Khan recognized that something was “off” about Winnicott’s vision of him:

D.W.W. is so fond and proud of me and yet so ill at ease with me.
I have only now realized that D.W.W. is rather afraid of me (God alone knows why!) and covers it up with awkward bantering.

(Hopkins, 2006, p. 154)

Was Khan dissembling when he disavowed his power over Winnicott, or did he also feel anxiety about that power? Certainly, he expressed much appreciation and admiration for his analyst. Khan spoke movingly about Winnicott’s capacity to meet his needs in his Work Books (Hopkins, 2006, p. 153). And his Introduction in Through Pediatrics is lovingly admiring, indeed, idealizing. But it’s not clear that Winnicott resided “outside” these visions, retaining an awareness of his less than perfect responsivity. I wonder whether Winnicott instead embraced an analytic ideal of maternal bounty, joining, and indirectly encouraging, patients’ visions of him.

We have some direct evidence of Winnicott’s active participation in dyadic idealizations from Guntrip’s (1996) account of his analysis with Winnicott. That analysis is generally viewed to have been relatively successful, if incomplete; Guntrip believed that his work with Winnicott went well beyond his first analysis with Fairbairn in its therapeutic effects.

But Guntrip’s idealization of Winnicott was far from unilateral; in his narrative account of that analysis he quotes Winnicott:

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.

(1996, p. 750)

Here, Winnicott acknowledges what’s more often harbored as a secret pleasure—that Guntrip’s idealization of him represented an antidote to Winnicott’s own bad feelings about his (analytic) self. Interestingly, Winnicott’s discomfort with that investment is also clear, if indirect; Winnicott declares that he doesn’t need the good feeling he derives from Guntrip, a declaration that I read as savavowal.

I’m suggesting that Winnicott and Guntrip established a more symmetrical and mutual idealization than did Winnicott and Khan. That idealization was strikingly monochromatic in affective tone; neither Guntrip nor Winnicott could tolerate or fully recognize the other’s nonideal subjectivity in this context—there was no room for anger or disappointment between them (Eigen, 1993). And Khan sensed something similar in his analyst, a longing to be idealized hidden beneath a rather self-effacing presentation:

I used to tease DWW that he was like Dostoevsky’s “Idiot” . . .: abjectly passive and presenting himself unintegrated, but in fact all unshakably there, sure of himself, contemptuous of others . . . and convinced he was the only “original and true” analyst.

(MK, WB, January 29, 1980)

If Winnicott did wish to be idealized, though, that wish wasn’t fully met by Khan. In his Work Books, Khan quotes Winnicott as expressing some regret concerning his patient’s failure to be “in love” with him: “You never had a real analysis and transference with me because you were so much in love with Beriosova all those years when you came to analysis!” (Beriosova was the great ballet dancer with the Royal) (MK, WB, February 4, 1980).

It’s worth noting that this regret articulated only a portion of Winnicott’s theory of therapeutic action. He also wrote extensively about the value and centrality of anger in development and analytic process, emphasizing the analyst’s—and mother’s—survival in the move from object relating to object usage (Winnicott, 1971). Nevertheless, Winnicott seems to have been more comfortable in an idealized parental position than as the subject (or object) of anger, (which, Hopkins, 2006, suggests, he didn’t always “survive”). Did Winnicott’s need both to be admired and to admire foreclose his ability to address Khan’s conflicted feelings about him (Goldman, 2006; Hopkins, 2006)? I think so, but I suspect that it took two; Khan’s provocative, often contemptuous stance toward his analyst likely contributed to Winnicott’s idealization.

Khan’s Work Books contain arrogant, dismissive, and critical comments about Winnicott, a quality that is also conveyed in some of Khan’s letters to his former analyst:
Your paper on Psycho-analysis in Childhood is competent, but I am afraid it is not vastly exciting, but then I am sure it was not meant to be so and that it met the needs of your audience.

(September 26, 1962)

Khan’s rather shockingly contemptuous tone stands in stark contrast to Winnicott’s overt admiration for his analysand. Was this a tacit pact between them, a superficially joint idealization that masked underlying sado-masochistic dynamics—a painful underbelly to this analytic relationship?

**Psychoanalytic collisions and the analyst’s humanity**

When idealizations don’t exist in tension with actuality but as a single relational thread, they become thick and impenetrable. Protective walls are erected to shield the relationship from disruption; analyst and patient lose contact with the richness of free, collaborative exchange. Affects like disappointment, anger, and rage aren’t merely bracketed (Slochower, 1996a; 2014) but utterly negated, as patient and analyst together deny, dissociate, even obliterate the negative.

On one hand, Winnicott’s sensitive capacity for holding seemed essential as a stabilizing force in Khan’s life. On another, Winnicott’s investment in being idealized may have limited his capacity to move Khan’s—and perhaps other—treatments beyond a certain point. Winnicott’s focus on the value of holding and regression occluded both a systematic exploration of how disturbances of the holding space function therapeutically and the potential nontherapeutic impact of meeting need. Yet Winnicott had a most nuanced understanding of psychoanalytic process and the variability of patients’ issues; he believed that regression was necessary only for the most vulnerable. And despite an idealized vision of the maternal analytic function, he also argued that mothering must only be good enough. He spoke explicitly about the value of (useful) maternal hate and the centrality of the spontaneous gesture in alive relatedness. Characteristically prescient was a 1969 paper entitled, “The Mother-Infant Experience of Mutuality,” in which he underscored the importance of mutuality in intimate relationships (Winnicott, 1989a). Most important, Winnicott’s papers on object usage and hate in the countertransference make clear that he was profoundly aware of the therapeutic value of destruction in the developmental trajectory.

There’s some evidence that Winnicott recognized his inability to sustain patients’ idealizations and had a wish to be seen for who he was, human and imperfect. In his description of work with a regressed patient acutely sensitive to disruptions, Winnicott tells us that despite his attempt to create an absolutely fixed therapeutic setting, he traumatically disrupts the holding space by rearranging items on his desk:

The patient comes into the room and sees these alterations, and... I find that this is a complete disaster... Eventually she asked me to talk about this, what had she done that made me make this mistake, a mistake which completely broke up the process of the analysis... In the end I was able to say “The thing is, this is what I am like, and if you continue with me you will find I shall do similar things with unconscious motivation because of what I am like.”

(Winnicott, 1989b, pp. 99-100)

Were those unconscious factors to which Winnicott attributed his behavior his own rebellion against a self-requirement to dwell within the realm of idealization? Winnicott certainly seems to acknowledge his professional limits here. And elsewhere, Winnicott (1975) articulates a nuanced view of idealization’s defensive function:

I wish to add the reminder that a good breast introduction is sometimes highly pathological, a defence organization. The breast is then an idealized breast (mother) and this idealization indicates a hopelessness about inner chaos and the ruthlessness of instinct. A good breast based on selected memories, or on a mother’s need to be good, provides reassurance.

(p. 276)

And

Analysts are faced with this difficult problem, shall we ourselves be recognizable in our patients... We hate to become internalized good breasts in others, and to hear ourselves being advertised by those whose own inner chaos is being precariously held by the introjection of an idealized analyst.

(1954a, p. 276)

Yet despite this acknowledgement, his idealized vision of the analyst’s capacity to hold and to be used remains implicit in his next statement: “What do we want? We do not want to be magically introjected; we want to be ‘eaten.’ There is no masochism in this” (Winnicott, 1975, p. 276).

Whether a genuine theoretical conviction or more dynamically shaped justification, Winnicott may have believed he had allowed Khan to “eat” him, that is, to make therapeutic use of him. This poetic (and to some extent, self-effacing) vision of the analyst’s desire embeds a striking idealization of the therapeutic function, for we analysts both want and dread becoming the objects of our patients’ desires. We may hope to be seen and used (eaten), as Winnicott suggests, but at times, we find this process unbearable and seek refuge from it—perhaps in our patient’s valorized view of us.
I suspect, then, that Winnicott’s need to be idealized remained unevenly met—and unmet—by Khan. Khan’s seductiveness, brilliance—and perhaps also his contempt—probably fueled Winnicott’s idealization of Khan. Did Khan, gratified in part by Winnicott’s admiration, also long for a different sort of recognition from his analyst—recognition of his destructiveness? I wonder whether Khan might have upped the anti of his misbehavior in an unconscious attempt to break through Winnicott’s idealization, enacting both his destructive rage and his need for a more human, less perfectly loving and accepting analyst.

Analytic ideals and analytic boundaries

Almost all analysts seek an ideal, a professional vision toward which to strive (see Chapter 10). This ideal, while intrinsically unreachable, represents a guide and model against which to gauge our professional work. Whatever our theory, we’re committed to disciplined attentiveness of a very high degree, to putting our patient’s needs first and studying our failures to do so. Yet despite the extraordinarily high standard to which we hold ourselves, it’s the very unusual analyst who has never broken a therapeutic rule or enacted aspects of her self-interest.16

But it’s extraordinarily difficult for us to think about our failures without excessive rationalization on one end or self-condemnation on the other. Our capacity to tolerate deidealization—a disruption of a positive professional self-image in our own and the patient’s eyes without destruction—creates more space for patients to notice and address these moments. By acknowledging, reflecting on and working with the impact of a breach, we reintroduce the sequestered into the therapeutic arena where it can be examined. Harris and Sinzheimer (2007) underscore the role of analytic self-care as central to this process. By attending to personal needs even as we struggle to maintain a commitment to the professional ideal, we can create an antidote to the excesses of that ideal.

Was Winnicott’s commitment to the maternal ideal so unshaded that it precluded self-care and self-reflectivity? Did he examine the complex shape of his relationship to Khan, struggle with self-doubt about the effectiveness of Khan’s treatment, worry about the clinical consequences of their professional involvement? Did he sidestep Khan’s misbehavior or address it with him?17

It’s not especially surprising that British Society analysts avoided confronting Winnicott with his breaches; this kind of avoidance is commonplace at every institute. It’s multiply determined. By calling a colleague on his or her breach, our own professional ideal may be seriously disrupted. To take the moral high ground with an esteemed colleague may also invite the breakdown of defenses against recognition of our own transgressions. On a more practical level, such actions invite censure of the tale-bearer, and this is never more true than when the transgressor has power.

Winnicott’s exalted stature in the eyes of many society members must have made it especially difficult for colleagues to confront him. Perhaps the collision between the shared idealization of Winnicott and the actuality of his failure was noted and then denied in a cross-generational collusion (Gabbard and Peltz, 2001; Sandler, 2004). Alternatively (or in addition), it’s possible that the group’s idealization of Winnicott was so powerful that it altogether occluded awareness of his failure—that some of Winnicott’s colleagues concluded that he “must” have known what he was doing with Khan. It’s similarly difficult to assess the role of professional self-interest—the desire to maintain a good relationship with Winnicott and those associated with him—in the silence that followed.

Conclusions: an alternate analytic vision

In focusing on Winnicott’s vulnerability to participating in processes of idealization, I am not attempting to indict Winnicott. First, none of us would fare well if our analytic skill were judged based on our worst case; second, we’re not in a position to evaluate just how much of a failure this analysis was. Winnicott’s own vulnerabilities and the pressures exerted on him by Khan certainly resulted in the breakdown of ordinary therapeutic boundaries and likely undermined the treatment relationship, but they need not lead to the destruction of our vision of Winnicott as analyst.

As Khan’s relationship with Winnicott developed, Winnicott was aging and often ill; Khan was alcoholic and deeply disturbed. Perhaps neither could tolerate the disruption that would have resulted had their shared idealization been dismantled. Winnicott’s death further undermined Khan’s need to sustain his special place with Winnicott: his discovery that Clare Winnicott (rather than him) had been entrusted with his analyst’s writings brought an end to that. A trauma in its own right and perhaps also a symbolic embodiment of earlier injuries (après coup), the persistent collision of actuality with the ideal contributed to Khan’s final and tragic collapse.

Winnicott’s failure with Khan broke into our own rather rigid idealization of him and shattered the image that we had come to love, that we loved to love. Let us not turn to the underbelly of idealization by destroying another professional ideal; let us humanize him instead.

Notes

1 My psychoanalytic world is American—relational, object relational, and Freudian. Most of my interpersonal colleagues don’t share my love of Winnicott. He also has had vocal critics among some American relational writers (and, of course, among members of the British society). And although we do not all revere Winnicott, I suspect that we all revere someone. This other psychoanalytic giant, perhaps Freud, Klein, or Lacan, provides an alternate analytic ideal toward which to aspire and confronts us with the dynamics I describe here.
2 Diethelm Library, Institute for the History of Psychiatry, Weill Medical College of Cornell University.
3 Concurrently, I participated in presentations about Khan and Winnicott with Dodi Goldman and Linda Hopkins that further stimulated my thinking.
4 For the analyst in training, this idealization often organizes around therapeutic competence: "You're a better analyst than I'll ever be." This same dynamic sometimes plays out within the supervisory context.
5 Hopkins (1998, 2006), Willoughby (2005), and Goldman (2006) have all explored Khan's gradual deterioration as an analyst in the context of an extensive study of his personal and professional life. Their work and subsequent discussions of the Godley affair by Boynton (2005) complicate any uni-dimensional indictment of Khan. Khan wrote sensitive and rich clinical books and introduced Winnicott's own work with delicacy and, it seems, love.
6 In fact, Hopkins reported that Charles Rycroft (as cited in Hopkins, 2006, p. 143) is "100 percent sure" that Khan "literally wrote" several of Winnicott's papers. This was supported in Hopkins interview of IPA secretary Ann Jameson, who recognized Khan's handwriting on Winnicott's manuscripts. (Willoughby personal communication) disagrees, believing that Winnicott would never have permitted this and that Khan acted as editor rather than ghost writer."
7 In this widely discussed incident, Little breaks a vase of Winnicott's and he leaves the room for the duration of the session, returning only at the end. He replaced the vase without discussing what happened (Little, 1990).
8 It's possible that this idealization was sexualized—that disavowed homoerotic longings found their way into an erotically tinged admiration for Khan.
9 Of course, we can't identify what Winnicott actually felt from these letters. It's quite possible that only some of his feelings about Khan found their way into them.
10 Winnicott concludes the letter by also recommending his patient Margaret Little: "I would also like to remind you that Margaret Little could be valuable to you."
11 Did Khan express genuine admiration for Winnicott here, a longing for a parental relationship with him, or "false self" expressions of admiration, the quid pro quo felt to be required of Khan as Winnicott's protégé?
12 Eigen (1993) suggests that Winnicott had no choice but to allow the idealizing transference to develop because Guntrip couldn't have tolerated treatment without it. However, Eigen also notes that "Guntrip was trying to mold his actual emotional reactions in light of an idealized theoretical possibility: how it might be in a perfect world . . . . The atmosphere of mutual mirroring likely contributed to muting anything unpleasant which could spoil the gratifying communion" (p. 142).
13 Willoughby (personal communication, May, 2007) has suggested that Khan's report of this and other interactions between himself and Winnicott cannot be relied on. He and Judith Issoff believe that Khan's Work Books are far from accurate and instead are replete with Khan's playful (or destructive) lies.
14 Willoughby (2005) underscores the role of lieutenancy and pseudo-mentorship in sustaining this idealization.
15 According to Hopkins (2006), Winnicott didn't sufficiently remind Khan of his idealized father and was far too undignified for Khan's taste.
16 In this context, Winnicott's desire to collaborate with his very talented patient Khan might be read as an example of the invasion of analytic self-interest, a phenomenon with which we're all familiar.
17 Many such rules were routinely disregarded in this period of psychoanalytic history.