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A More Usable Winnicott

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In this article, I hope to amplify certain basic features of Winnicott's theories to provide a more elaborate explanation for the following: (1) the nature and primary source of anxiety in his model. (2) The major points of fixation and developmental arrest that give rise to pathological character formation. Here I detail the anatomy of the false self, as one principal way the psyche reorganizes to defend against anxiety, the awareness of depressive feelings, and a chronic incapacity to manage tension states. I also describe an alternative way the individual might achieve an alternate solution, with an emphasis on archaic forms of grandiosity. Finally, (3) I emphasize the role of affects, especially the consequences of the failures in their management, to give a crucial role to what I call the second dimension of caretaking failure. In the analytic work, this second dimension becomes not only important but, at times I claim, the leading edge of need.

I do not review Winnicott's developmental model in detail here. A more extensive review can be found in my papers, "Ordinary People," and "The Capacity to use the Analyst."

Winnicott (and to a great extent Kohut) viewed patients who suffer from developmental and self disorders as communicating their disturbance through their characters, their symptoms, and their seriously compromised object relating. They both see the adaptive/maladaptive character pathology as an admixture of need (the forward edge) and defense. The needs imbedded in the presenting personality—often distorted—have been carried forward in derivative form from earlier times. The defenses, for the most part, are motivated by the fear of retraumatization, exaggerated by the dread of reliving disappointments and the attendant unintegrated feelings. This latter anxiety is heightened because the patient's structure is frequently weakened due to the lack of a secure internal holding environment.

Both Winnicott (1958) and Kohut (1971) traced the source of these problems to early developmental failures that have left the patient vulnerable to reinjury. They recommend that analytic treatment facilitate a regression that remobilizes the needs that have been repressed and/or compromised. The theory of therapeutic action also includes the analyst making himself or herself available as a new object.

Because I have posed that the presenting character pathology demonstrates the continued need for earlier objects (mirroring, idealizing) to provide responses to the true (nuclear) self, the analyst should welcome transferences that carry these needs. But equally crucial is the fact that the patient's adaptive/maladaptive organization is also designed to contain and control the

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awareness of chronically feared affects, as well as to prevent the awakening of affects associated with earlier frustration. Therefore, a second dimension or need will be for the analyst to be available to aid in affect management. By attributing the major point of developmental trauma to the time at which object (self) relations are most critical for structure building, the remobilization of the needed objects for rehabilitation of the self becomes a primary concern.

Because so much of the rationale for the treatment is based on the early developmental failure, let us look at how Winnicott understood the relationship between past trauma and current therapy.

WINNICOTT'S VIEW ON DEVELOPMENT AND THE EFFECT OF ENVIRONMENTAL FAILURE ON ARREST

After focusing his attention on the important role of the mother in providing a good enough response and on the omnipotent gesture, Winnicott delineated two potential outcomes. The first leads to a healthy self strengthened by the mother's capacity to accept her role in the child's phase-appropriate grandiosity. Sufficient immersion activates processes that catalyze the infant's gradual recognition and acceptance of a source of nurture outside of his sphere and illusion of control. Along the way, inevitable disappointments, frustrations, and minor injuries cause powerful affective storms that the good enough mother helps contain and integrate. This second function, a dimension needed for affect regulation and ego strengthening, is vitally important in solidifying the child's self and providing enough security to allow for true dependence (a usable external object).

However, Winnicott's explanation for an unfavorable outcome seems to be insufficiently comprehensive or compelling. By this I mean that his explanations for how environmental failures, in this crucial phase of development, lead to an imbedded and chronic sense of dysphoria, a vulnerability to anxiety, and the need for psychic reorganization, is much too simple and understated for the kind of pathology that unfolds.

He essentially says that the caretaker's inability to reliably gratify the illusion inherent in the omnipotent gesture interferes with the infant's "going on being." The cause of this disruption is attributed variably to a narcissistic, impatient, intrusive, overly critical, or otherwise unattuned parent. Although Winnicott was clearly aware of the reactive negative feelings that accompany the disruption, there is too little emphasis put on the way failure to hold the affects influences or contributes to the derailment of the future development. He has introduced one of the most crucial concepts in clinical theory—the parents' ability to "survive destruction." Yet he does not really spell this out to underscore its importance. To say that the parents' incapacity to hold intense affects leads to a freezing vastly underplays the role affect management has for the maturational process. Survival of destruction is, of course, a metaphorical concept, which describes the capacity of the parents to meet, validate, and at times absorb their child's protests, rages, and dysphoric moods. Providing this function allows for an integration of feelings and strengthening of the child's psychic structure. The child who can feel confident that his parents will remain available in the face of "affect storms" can afford to relinquish psychological control (or the illusion of such control), and thus place the object outside of himself. This is a major step in moving toward usability. It is such a crucial

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dimension of selfobject function that it deserves to be elaborated and given a primary role as a transference need.

AN ATTEMPT TO ELABORATE THE EFFECT OF ENVIRONMENTAL FAILURE, WITH AN EMPHASIS ON THE SECOND DIMENSION OF NEED (A HOLDING FUNCTION)

Let us then try to examine more closely the seismographic effect of environmental failure as it occurs during the crucial stages described above.

When there have been repeated disruptions that add up cumulatively (M. Khan) to trauma for the infant, there is a serious impact that registers as either a feeling of being dropped and abandoned, or as the self being disrupted by out-of-phase intrusions. Along with these self state breaks, there are intense reactive affects—communicating a loss of the needed object (selfobject), with an attendant sense of dysphoria and rage. How these accompanying negative feelings are managed by the caretakers is extremely important. If the object (selfobject) or caretaker is too critical, too dismissive, or out of tune, this constitutes the second dimension of failure. Now both object (selfobject) failures are internalized—i.e., there is the recognition (possibly the unthought known of Bollas) of the object's not being responsive enough to provide a sense of the self. There is also the knowledge (again, possibly only preverbally recorded) that the object will not be able to support negative affects.

If we could posit this two-fold failure as being internalized, we would have the following schema highlighted.

THE ANATOMY OF THE FALSE SELF

In the face of a consistent failure of the environmental objects (also referred to as *caretaking* or needed selfobjects), the infant begins to live with an *internalized object* that is essentially negative and feared. The quality and nuances of the toxicity will vary greatly, based on the particular parent–infant dyad. Simply put, though, the result of the failure in the good-enough, mirroring, emotional responsive function is to create a core experience with an introject that may be seen as critical, anxious, emotionally unavailable, excessively narcissistic, and/or intrusive.

Let me point out that the infant's self has internalized this experience—something along the lines of an RIG (response, internalized, and generalized; Daniel Stern)—and is therefore constantly in danger of being in contact with this negative or frightening experience. The fear of bumping into the hostile introject and the danger of being aware of the sense of loneliness or injury such contact would evoke give, I believe, a more compelling explanation in Winnicott's model for anxiety and depression.

But there is a second and equally important motive for the infant (patient) dreading an awareness of his *core* internal objects. As already stated, the events that follow the consistent frustration and disappointment in the objects so necessary to provide support and positive feeling for the true (nuclear), authentic self constitute an intense, reactive affective experience. When the same caretakers also fail to help the infant manage, contain, and integrate these intense emotional states,

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one can call this the second dimension of object (selfobject) failure. This creates a compound dilemma for the infant. Not only does he have a dread of bumping into the not-good-enough mother (the chronic thwarting of emotional sustenance), but he is also frightened of the terrifying feelings that have never been managed. This lack of structure leaves the infant chronically anxious about the emergence of any uncontrolled affect states.

In describing this second dimension of selfobject failure, a central feature is the concept of *survival of destruction*. When the parent who has been part of an emotional storm over time is not able to provide the holding experiences, a watershed situation occurs. However the parent's failure manifests itself—through excess criticism, withdrawal or, most damaging, lack of validation (validation being immensely important in healing) —the infant registers it (most often unconsciously) as a lack of reliability of the object.

More pointedly, the parents' inability to provide a regulating presence, contain intense rage, accept their part in a current disruption by absorbing negativity while maintaining a sturdy presence, all contribute to the *failure to survive*. Thus, the child now has to live with this two-fold internal danger. On one hand, to hope for authentic responses to core needs subjects him to possible disappointment. On the other, when he exposes himself to injury and accompanying reactive feelings, his objects will not stay with him and/or his psychic structure will be overwhelmed. Here is where one sees the basis for the formation of the false self or, as I describe later, another required psychic reorganization around the grandiose self.

In essence, the infant who has internalized this two-fold failure needs to create a situation which serves the following purposes:

1. Try to keep from being aware of his toxic introjects.
2. Keep his central needs from being mobilized.
3. Form a compromise bond with the object (e.g., the mother).

Under this latter heading, one should also consider that the way the false self bond is constructed is that the child helps create the illusion of a responsive mother. Psychologically, this is the concept of subjective relating being in a state of arrested development. Under optimal conditions, the infant gives up the illusion of control and moves to a position that acknowledges that the object is outside of the self, and places it there. This step leads to true dependence and usability. But because of the environmental trauma and the way it shapes the internal world, the object must be controlled psychologically, at least in fantasy. Accommodating to the mother and shaping oneself to her needs helps maintain the illusion, and contributes to the fiction of a responsive mother. In addition to creating a form of connectedness, this new bond helps quiet the noise that would come from recognizing the core of the self and its relationship to the failed and frightening objects.

In summary, the false self provides the fiction of a good relationship and controls the recognition of the toxic core relationships. It is built on an original distress, and serves the need to keep the *true self* in a state of repression.

I hope that, by expanding or at least elaborating the interplay between environmental failure, the shaping of the internal world, and the need for compromise reorganization between self and objects, I am sufficiently emphasizing the role played by both dimensions of failure (or, one might say, selfobject failure). Eventually, I want to utilize this as a foundation and rationale for the analysis and what is required of the analyst in the ensuing therapeutic action. Let me suggest the following.

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AN ALTERNATE SOLUTION NECESSITATED BY TRAUMATIC ENVIRONMENTAL INTERFERENCES

I now focus on the second common characterological solution necessitated by traumatic environmental interferences that occur in the period during which the omnipotent gesture and subjective relating should become transformed into a greater acceptance of reality and object usability. Although the environmental traumas are due to significant narcissistic vulnerability in the parent, the empathic failures center around an out-of-tuneness with the phase-appropriate needs of the child. Although the faulty caretaking in these instances often features an overemphasis on the child's grandiosity or on an unrealistic and selective responsiveness to precocious talents (see M. Khan), these environmental failures, nevertheless, are as malignant to developmental growth as are those that lead to a *false self* solution. Although, on the surface, the infant who is overvalued or chosen receives more than enough supplies, closer examination and analytic work will begin to expose the real emotional deprivation, as well as a chronic sense of loss of needed sustaining objects. The internal world of such children may also represent core disappointing or even frightening objects (selfobjects), or the caretakers may be perceived as excessively narcissistic and/or intrusive. They quickly intuit that their specialness has less to do with them than with the needs of the parents. Similarly, how their reactive affects—especially negativity—were managed may reveal the same problems as those found in individuals who organized themselves around a false self. They, too, have internalized a two-fold failure and, in turn, one can begin to understand how their character pathology becomes a new organization designed to both preserve a forward edge of need and contain and defend against retraumatization and the awareness of unmanageable affects.

In discussing some of the scenarios that help shape individuals who remain fixated at the stage of archaic grandiosity (omnipotent gesture), I show that these children borrow from the environment those responses that reinforce their character. For example, certain children may be selected early in life to form a special bond with the mother. Often, beneath the apparent overabundance of maternal supplies are great deficits in balanced and sustained support. Over time, these children may experience an erratic quality to the mirroring and admiration. Often, too, they may realize that the connection is conditional, and they can feel dropped if they fail to provide a necessary function for the parent. This may lead to feelings that it is only through calming and being an object for the parent that they can feel part of a tie. In all of these cases, the child can register—if not fully experience—the tenuousness of the tie and the dreadful recognition of not having a separate existence. The pain and potential depressive affects associated with this awareness are often minimized, repressed, or walled off. In addition, if there were accompanying protests or demonstrations of negative feelings, these too may have been dismissed, criticized, or invalidated. If so, this can also be a manifestation that is internally recorded as the parents' incapacity to tolerate negative or dysphoric feelings—that is to say, that they cannot survive destruction.

One can now see how the child might be coopted into a special bond in which his unique and precocious talents are exploited in the service of hypercathexis of the grandiose self. This collusive bond, however seductively gratifying, becomes a fragile substitute for genuine maturational growth. The final character solution may show many features of those whom one considers to have an archaic grandiosity or who require a great deal of control over and response from the external world. Their capacity for authentic and mutual exchange may be greatly limited.

Many individuals so coopted and exploiting a special bond with a parent may be socially charming and seemingly quite gregarious. Often, however, they too may reveal, either to

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themselves or through the impact they have on others, that they seem otherwise engaged. In time, the limitations of their brittle character may lead to problems in relationships or work, which result in their entering treatment. Through immersion in treatment, it is then possible to see how both dimensions of earlier object (selfobjects) failures and need are revealed and "resisted."

MODELL AND BROMBERG

Arnold Modell (1990), writing from a Winnicottian, and Bromberg (1983) from a relational perspective, have beautifully described patients who present with some form of archaic grandiosity. Both writers artfully and sensitively portrayed individuals who require a special kind of responsiveness to begin to make use of treatment. Modell was particularly attuned to a form of relatedness that he called a "non-related relatedness," which characterizes the patient–analyst interaction. In this mode, apparently, the patient seldom, if ever, acknowledges the separateness of the analyst. References to the meaning of the analyst or acknowledgment are almost nonexistent. Acknowledging the potential for countertransference reactions Modell, by implicitly tracing the patient's fixations to a time along the axis and developmental line of the omnipotent gesture, could see the possibility that, if the analyst provides an accepting holding environment, an analytic experience may evolve. He recommended that the analyst respond empathically to the patient, allowing the latter to find in the analyst the object he needs. It is usually a therapeutic plan that permits the patient to safely regress to the point at which the omnipotent gesture (grandiose self; Kohut, 1971) had been derailed. Empathic acceptance facilitates the patient's creation of a new object experience, one that is differentiated from earlier, toxic experiences (intrusive, narcissistically demanding, disillusioning, weak, etc.)

Bromberg (1983) saw in the patient's presentation a rigid demand for responsiveness, especially those responses that mirror and echo the patient's affects and experience. Bromberg, too, saw this as deriving from early fixations that interfered with the patient's transitioning to more mature and flexible ways of relating. His recommendations for treatment have many areas of similarity with those of Modell. He saw the need to maintain a delicate balance that accepts the patient's insistence on mirroring while recognizing the resistance to acknowledging the transference. Bromberg spoke of an anxiety–empathy gradient that can be utilized by the analyst to titrate resistance and transference interpretations based on the patient's capacity to tolerate them.Although Modell (1990) and Bromberg (1983)—and, before them, Winnicott (1958)—have advanced the grasp of the effect of early environmental influences on the arresting of the child's self at the level of the omnipotent gesture, their major emphasis has been on the forward edge of need. However, they have minimized the way the lack of affect management and the dread of feelings motivate and shape character pathology. By putting significant weight on patients' chronic anxiety related to their lack of ability to manage affects, one can more fully appreciate why they must resist what they so desperately need. The inability to tolerate their dysphoria and the fear that new relations will bring retraumatization and disorganization determine factors of resistance. This also means that, in the course of analytic work, the need for a new object that is available to help navigate emotional depths and contain and absorb negative affects is essential to engage and relive emotional trauma.

Both Modell (1990) and Bromberg (1983) were well aware of the clinical literature (e.g., Klein, Kernberg, etc.) that stresses narcissistic presentations as essentially determined by

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resistance. Although Bromberg's orientation was relational, he, like Modell, reflected the idea that the patient's character pathology, specifically his adaptive/maladaptive pattern of relating to external objects, communicates a psychic weakness and underlying vulnerability. Modell's debt to Winnicott's influence is to localize the pathognomonic point of fixation to the thwarting and intrusion upon the fragile emerging omnipotent self. He deepened and expanded Winnicott's clinical views by identifying the nonrelated relatedness transference as being an edge (albeit distorted) of need for a new object. By placing the point of fixation in the prestructural period he, like Winnicott, endorsed the patient's strivings in the analysis as a need, not simply an illegitimate infantile wish. Bromberg's model may differ somewhat, but in his empathic perspective he saws the same kind of patient requiring a similar period of holding, including an acceptance of the fragility of his structure.

In their well-intentioned efforts to counter the excesses of resistance analysis and the tendency to define narcissistic character as mainly defensive, Modell (1990) and Bromberg (1983) added significantly to providing a receptive and nonadversarial atmosphere for patients.

However, one is left to account for the lamentable problem that many patients who have suffered early injury are not easily able to utilize empathic immersion alone. In these cases, I believe one should reemphasize the two-fold nature of the early trauma and its influence on these patients' character as founded on defensive needs, as well as on the hope of establishing new *libidinal objects*" (including mirroring and idealizing objects). Therefore, I feel that, when one finds one's self in the experience where the transference seems to be minimized, negated, or nonexistent, one is always making diagnostic assessments. These include self-discourses that consider one's own needs and countertransferences. One also has to try and evaluate to what extent the patient's apparent narcissistic presentation, as it manifests itself in unique transferences (seemingly nontransferences) is part of the emergence of the needed true self (the original omnipotent gesture), and how much is part of the defensive process. (See Modell's 1990 selfobject defense paper.)

My hypothesis is that, in ther enthusiasm to correct the excesses of resistance analysis, analysts are possibly missing the patients' dread of giving up their major avenues of self-preservation. To this I add that a major motive for tenaciously maintaining a status quo and the hesitancy to make use of a new (analytic) object entails dread of affects.

In essence, accepting dependence on a new object requires acknowledging the deepest and most painful disillusions with the original objects. This recognition forces, in turn, a connection to the core introjects, and mobilizes affects—especially negative affects (perceived as destructive)—never before truly managed. Let me elaborate with an illustration.

CLINICAL ILLUSTRATION

The following example, taken from Ingmar Bergman's film *Autumn Sonata*, illustrates the two-fold stages that interfere with achieving usability, and provides material to hypothesize what the course of therapeutic action with the central character, Eva, might be.

In the film, viewers are introduced to her by Victor, her gentle, adoring husband, who tells them that he loves her dearly but, although she is herself kind and affectionate, she cannot seem to accept his love or be nourished by it. The stimulus for the movie is the impending visit of Eva's mother, Charlotte. Victor is apprehensive because he fears that his fragile wife has muted,

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but essentially unrealistic, expectations for the reunion. As Charlotte, a concert pianist, drives up, she too is nervous, filled with a mixture of tension and excitement.

Another character enters this drama: Helena, Eva's bedridden and barely intelligible sister (possibly an alter ego). Helena has a vague but devastating neurological disorder, which has left her in need of constant care by Eva. Viewers quickly learn that Charlotte has abandoned Helena and can hardly stand to see her. From the quiet and polite chords that begin the visit, the tempo accelerates and rises to a painful crescendo, underscored by a confrontation between Eva and Charlotte, and with a painful coda of an unresolved finale. However, before the climactic scene arrives, a pivotal moment occurs between Victor and Eva. Shortly after Charlotte's arrival, following the initial superficial niceties, Eva seems a bit deflated. As she and Victor set the table for diner, he says, "I long for you." She replies, "I distrust anyone who proffers such statements while in the same room." This declaration, which underscores the issue of usability, will become a pivotal metaphor in the treatment.

From this point on, the stilted strains of the film give way to a rising tide of emotions. After dinner, Charlotte, learning that Eva has taken up the piano, entreats her to play. Reluctantly and shyly, Eva does so. Charlotte listens, showing barely restrained disappointment; she corrects Eva, demonstrating how the piece should be played. Then, all hell breaks loose. The emotions of a lifetime, corseted by falseness and compliance (which have gnarled Eva up like the neurologically crippled Helena) come flooding out. In a growing rage, she makes her mother aware of how she, Eva, has twisted herself into a pretzel in an attempt to be pleasing and lovable. Seemingly, nothing about her was right—her skin, her hair, her clothes, her body, all were judged and corrected by her exacting mother. Despite Eva's best efforts, nothing was ever good enough. Time and again, mother would leave the family for extended concert tours and affairs. The intensity of Eva's rage frightens and shocks her mother, who self-righteously defends herself, and finally weeps and withdraws. Next morning, she is quickly gone, restituting herself through reimmersion in her performance schedule.

Continuing with this clinical illustration, imagine that Eva is so shaken by this encounter that she comes to therapy.

The immediate help she needs is with her now fully realized depression, and she can no longer deny her sense of unlovability and the amount of rage that has been residing within her. The aforementioned scene, which she recounts, is essentially the first time she has ever dared to communicate honestly with her mother, and not only did she feel misunderstood, but what she had always feared, that her authentic feelings would be rejected, came to pass. Although she knew that what she expressed felt real, she (sufficiently) doubted her right to say these things. Instead, she suffered feelings of guilt. Although these were the most pressing concerns motivating her to seek help, she also wanted to explore, over time, what she knew caused her husband pain—her inability to feel loved. At the deepest level, she feared that she herself was unable to love, and this was a great loss.

In the early stages of treatment, Eva says, prophetically, that she knows her husband, Victor, is a warm and giving man, but she has a great deal of difficulty accepting his love or believing he can love her. She recounts the pivotal exchange between them when he said, "I long for you," and she replied, "I distrust anyone who proffers such statements while in the same room." Her mind flashes to a scene when she is 12 and anxiously waiting to bring her mother coffee during a rehearsal break. Her mother's feigned pleasure at seeing her as she enters quickly gives way to a peremptory dismissal. This critical memory, a condensed and telescoped amalgam of

analogous experiences, has acted as the organizing nodal scene for Eva's defensive character adaptation. As one is to learn in the analytic work, whenever moments of deepening intimacy developed between Eva and her analyst, she would mobilize this scene. Either in associations or in dreams, the lesson to be learned was that warmth is an illusion; this is not real; the hoped-for embrace will never occur. Therefore, close the door, resurrect the barriers, and shut out your expectations and needs. It was this defensive configuration that would be reprised repeatedly. The poignant tragedy was that, however compelling her longings for intimacy were, the fear of retraumatization prevailed.

Gradually one learns that her fear of closeness and the activation of her dependency needs were more complex. Although much of the analysis was concerned with the danger of being reinjured if her needs were known, associations emerged that revealed another equally powerful motivation for her protective armor: the containment of disregulated affect states. Her dreams begin to focus on the dramatic confrontation she had with her mother. She now brought more directly into the treatment the many ways she had accommodated and shaped herself to adapt to her mother's needs, trying to be mother's special girl. As she had in reality, she attacked with uncanny accuracy the mother's selfishness, narcissism, and unavailability in the form of the analyst. In her dreams, she, Eva, turned her rage once again at the mother. The latter would become defensive and finally leave the house and Eva.

All of these revelations provide a fuller explanation of the motivation for Eva's need to resist the available object, a usable husband, analyst, or friend. For not only did she fear the trauma of rejection and the dismissal of her needs, but she especially feared her reactive rage, which she had much reason to believe could never be managed or held. She suspected—and then confirmed—that her mother could never survive her daughter's negative affects, and this failure led to a constriction in all her relationships. Of course, as her deeper longings became mobilized in the analysis, the analyst would inevitably fail her at times, and then would have to live through her intense despair and rage. Although these moments were difficult, reminding himself that the reactivation of these affects was life-saving and the survival of them crucial would better enable him to hold the situation. Becoming potentially usable to a patient who has been so deeply injured is never easy, because of the complexity and two-fold nature of the trauma. The possibility for a new beginning and the capacity to love involve providing safe conditions for the emergence of needs and a chance to successfully relive despair and anger.

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SUMMARY AND CONCLUSIONS

In gauging patients' presentations, analysts are continuously processing which dimension of need is in the forefront. For many patients, a climate that includes acceptance of the transference or nontransference, and/or making use of countertransference reaction, is the necessary provision that facilitates and allows for a deepening regression, a fuller elaboration of need, and potentially a new usability of the analytic object. For other patients—often those who present with a clearer false self adaptation—it may become clear that what is most essential is introducing or engaging feeling states. Because the dread of their deeper emotional life and the associated anxiety about how well their objects will manage their negative or dysphoric affects are paramount, addressing these issues may be the beginning paradigm for a new holding relationship. It may only be after a period when the feared negative affects—toward the parents or the analyst—are

brought into focus that the patient may begin to feel safe enough to mobilize more positive longings.

Similarly, with patients whose archaic states of grandiosity are predominant over time, the tenacious maintenance of their patterns of relating and controlling the environment may require some interventions that address their profound fear of disillusionment and the fear of disorganizing feelings associated with this.

Speaking to this aspect of character armor is an attempt to relate to the defenses embedded within. But it is based on the understanding of how vulnerable the underlying structure is to unintegrated affects and the persistent danger that they will not find or be able to trust objects to stay with their disappointment and pain.

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