

## FEAR OF BREAKDOWN

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### PRELIMINARY STATEMENT

My clinical experiences have brought me recently to a new understanding, as I believe, of the meaning of a fear of breakdown.

It is my purpose here to state as simply as possible this understanding, which is new for me and which perhaps is new for others who work in psychotherapy. Naturally, if what I say has truth in it, this will already have been dealt with by the world's poets, but the flashes of insight that come in poetry cannot absolve us from our painful task of getting step by step away from ignorance towards our goal. It is my opinion that a study of this limited area leads to a restatement of several other problems that puzzle us as we fail to do as well clinically as we would wish to do, and I shall indicate at the end what extensions of the theory I propose for discussion.

### INDIVIDUAL VARIATIONS

Fear of breakdown is a feature of significance in some of our patients, but not in others. From this observation, if it be a correct one, the conclusion can be drawn that fear of breakdown is related to the individual's past experience, and to environmental vagaries. At the same time there must be expected a common denominator of the same fear, indicating the existence of universal phenomena; these indeed make it possible for everyone to know empathetically what it feels like when one of our patients shows this fear in a big way. (The same can be said, indeed, of every detail of the insane person's insanity. We all know about it, although this particular detail may not be bothering us.)

### EMERGENCE OF THE SYMPTOM

Not all our patients who have this fear complain of it at the outset of a treatment. Some do; but others have their defences so well organized that it is only after a treatment has made con-

siderable progress that the fear of breakdown comes to the fore as a dominating factor.

For instance, a patient may have various phobias and a complex organization for dealing with these phobias, so that dependence does not come quickly into the transference. At length, dependence becomes a main feature, and then the analyst's mistakes and failures become direct causes of localized phobias and so of the outbreak of fear of breakdown.

### MEANING OF 'BREAKDOWN'

I have purposely used the term 'breakdown' because it is rather vague and because it could mean various things. On the whole, the word can be taken in this context to mean a failure of a defence organization. But immediately we ask: a defence against what? And this leads us to the deeper meaning of the term, since we need to use the word 'breakdown' to describe the unthinkable state of affairs that underlies the defence organization.

It will be noted that whereas there is value in thinking that in the area of psychoneurosis it is castration anxiety that lies behind the defences, in the more psychotic phenomena that we are examining it is a breakdown of the establishment of the unit self that is indicated. The ego organizes defences against breakdown of the ego organization, and it is the ego organization that is threatened. But the ego cannot organize against environmental failure in so far as dependence is a living fact.

In other words, we are examining a reversal of the individual's maturational process. This makes it necessary for me briefly to reformulate the early stages of emotional growth.

### EMOTIONAL GROWTH, EARLY STAGES

The individual inherits a maturational process. This carries the individual along in so far as there exists a facilitating environment, and

only in so far as this exists. The facilitating environment is itself a complex phenomenon and needs special study in its own right; the essential feature is that it has a kind of growth of its own, being adapted to the changing needs of the growing individual.

The individual proceeds from absolute dependence to relative independence and towards independence. In health the development takes place at a pace that does not outstrip the development of complexity in the mental mechanisms, this being linked to neurophysiological development.

The facilitating environment can be described as *holding*, developing into *handling*, to which is added *object-presenting*.

In such a facilitating environment the individual undergoes development which can be classified as *integrating*, to which is added *indwelling* (or *psychosomatic collusion*) and then *object-relating*.

This is a gross over-simplification but it must suffice in this context.

It will be observed that in such a description forward movement in development corresponds closely with the threat of retrograde movement (and defences against this threat) in schizophrenic illness.

#### ABSOLUTE DEPENDENCE

At the time of absolute dependence, with the mother supplying an auxiliary ego-function, it has to be remembered that the infant has not yet separated out the 'not-me' from the 'me'—this cannot happen apart from the establishment of 'me'.

#### PRIMITIVE AGONIES

From this chart it is possible to make a list of primitive agonies (anxiety is not a strong enough word here).

Here are a few:

- (1) A return to an unintegrated state. (Defence: disintegration.)
- (2) Falling for ever. (Defence: self-holding.)
- (3) Loss of psychosomatic collusion, failure of indwelling. (Defence: depersonalization.)
- (4) Loss of sense of real. (Defence: exploitation of primary narcissism, etc.)

- (5) Loss of capacity to relate to objects. (Defence: autistic states, relating only to self-phenomena.)

And so on.

#### PSYCHOTIC ILLNESS AS A DEFENCE

It is my intention to show here that what we see clinically is always a defence organization, even in the autism of childhood schizophrenia. The underlying agony is unthinkable.

It is wrong to think of psychotic illness as a breakdown, it is a defence organization relative to a primitive agony, and it is usually successful (except when the facilitating environment has been not deficient but tantalizing, perhaps the worst thing that can happen to a human baby).

#### STATEMENT OF MAIN THEME

I can now state my main contention, and it turns out to be very simple. I contend that clinical fear of breakdown is *the fear of a breakdown that has already been experienced*. It is a fear of the original agony which caused the defence organization which the patient displays as an illness syndrome.

This idea may or may not prove immediately useful to the clinician. We cannot hurry up our patients. Nevertheless, we can hold up their progress because of genuinely not knowing; any little piece of our understanding may help us to keep up with a patient's needs.

There are moments, according to my experience, when a patient needs to be told that the breakdown, a fear of which destroys his or her life, *has already been*. It is a fact that is carried round hidden away in the unconscious. The unconscious here is not exactly the repressed unconscious of psychoneurosis, nor is it the unconscious of Freud's formulation of the part of the psyche that is very close to neurophysiological functioning. Nor is it the unconscious of Jung's which I would call: all those things that go on in underground caves, or (in other words) the world's mythology, in which there is collusion between the individual and the maternal inner psychic realities. In this special context the unconscious means that the ego integration is not able to encompass something. The ego is too immature to gather all the phenomena into the area of personal omnipotence.

It must be asked here: why does the patient go on being worried by this that belongs to the past? The answer must be that the original experience of primitive agony cannot get into the past tense unless the ego can first gather it into its own present time experience and into omnipotent control now (assuming the auxiliary ego-supporting function of the mother (analyst)).

In other words, the patient must go on looking for the past detail which is *not yet experienced*. This search takes the form of a looking for this detail in the future.

Unless the therapist can work successfully on the basis that this detail is already a fact, the patient must go on fearing to find what is being compulsively looked for in the future.

On the other hand, if the patient is ready for some kind of acceptance of this queer kind of truth, that what is not yet experienced did nevertheless happen in the past, then the way is open for the agony to be experienced in the transference, in reaction to the analyst's failures and mistakes. These latter can be dealt with by the patient in doses that are not excessive, and the patient can account for each technical failure of the analyst as countertransference. In other words, gradually the patient gathers the original failure of the facilitating environment into the area of his or her omnipotence and the experience of omnipotence which belongs to the state of dependence (transference fact).

All this is very difficult, time-consuming and painful, but it at any rate is not futile. What is futile is the alternative, and it is this that must now be examined.

#### FUTILITY IN ANALYSIS

I must take for granted an understanding and acceptance of the analysis of psychoneurosis. On the basis of this assumption, I say that in the cases I am discussing the analysis starts off well, the analysis goes with a swing; what is happening, however, is that the analyst and the patient are having a good time colluding in a psychoneurotic analysis, when in fact the illness is psychotic.

Over and over again the analysing couple are pleased with what they have done together. It was valid, it was clever, it was cosy because of the collusion. But each so-called advance ends in destruction. The patient breaks it up and says:

So what? In fact, the advance was not an advance; it was a new example of the analyst's playing the patient's game of postponing the main issue. And who can blame either the patient or the analyst (unless of course there can be an analyst who plays the psychotic fish on a very long psychoneurotic line, and hopes thereby to avoid the final catch by some trick of fate, such as the death of one or other of the couple, or a failure of financial backing).

We must assume that both patient and analyst really do wish to end the analysis, but alas, there is no end unless the bottom of the trough has been reached, unless *the thing feared has been experienced*. And indeed one way out is for the patient to have a breakdown (physical or mental) and this can work very well. However, the solution is not good enough if it does not include analytic understanding and insight on the part of the patient, and indeed, many of the patients I am referring to are valuable people who cannot afford to break down in the sense of going to a mental hospital.

The purpose of this paper is to draw attention to the possibility that the breakdown has already happened, near the beginning of the individual's life. The patient needs to 'remember' this but it is not possible to remember something that has not yet happened, and this thing of the past has not happened yet because the patient was not there for it to happen to. The only way to 'remember' in this case is for the patient to experience this past thing for the first time in the present, that is to say, in the transference. This past and future thing then becomes a matter of the here and now, and becomes experienced by the patient for the first time. This is the equivalent of remembering, and this outcome is the equivalent of the lifting of repression that occurs in the analysis of the psychoneurotic patient (classical Freudian analysis).

#### FURTHER APPLICATIONS OF THIS THEORY

##### *Fear of death*

Little alteration is needed to transfer the general thesis of fear of breakdown to a specific fear of death. This is perhaps a more common fear, and one that is absorbed in the religious teachings about an after-life, as if to deny the fact of death.

When fear of death is a significant symptom the promise of an after-life fails to give relief, and the reason is that the patient has a compulsion to look for death. Again, it is the death that happened but was not experienced that is sought.

When Keats was 'half in love with easeful death' he was, according to the idea that I am putting forward here, longing for the ease that would come if he could 'remember' having died; but to remember he must experience death now.

Most of my ideas are inspired by patients, to whom I acknowledge my debt. It is to one of these that I owe the phrase 'phenomenal death'. What happened in the past was death as a phenomenon, but not as the sort of fact that we observe. Many men and women spend their lives wondering whether to find a solution by suicide, that is, sending the body to death which has already happened to the psyche. Suicide is no answer, however, but is a despair gesture. I now understand for the first time what my schizophrenic patient (who did kill herself) meant when she said: 'All I ask you to do is to help me to commit suicide for the right reason instead of for the wrong reason.' I did not succeed and she killed herself in despair of finding the solution. Her aim (as I now see) was to get it stated by me that she died in early infancy. On this basis I think she and I could have enabled her to put off body death till old age took its toll.

Death, looked at in this way as something that happened to the patient but which the patient was not mature enough to experience, has the meaning of annihilation. It is like this, that a pattern developed in which the continuity of being was interrupted by the patient's infantile reactions to impingement, these being environmental factors that were allowed to impinge by failures of the facilitating environment. (In the case of this patient troubles started very early, for there was a premature awareness awakened before birth because of a maternal panic, and added to this the birth was complicated by undiagnosed placenta praevia.)

#### *Emptiness*

Again my patients show me that the concept of emptiness can be looked at through these same spectacles.

In some patients emptiness needs to be experienced, and this emptiness belongs to the past, to the time before the degree of maturity had made it possible for emptiness to be experienced.

To understand this it is necessary to think not of trauma but of nothing happening when something might profitably have happened.

It is easier for a patient to remember trauma than to remember nothing happening when it might have happened. At the time, the patient did not know what might have happened, and so could not experience anything except to note that something might have been.

#### *Example*

A phase in a patient's treatment illustrates this. This young woman lay uselessly on the couch, and all she could do was to say: 'Nothing is happening in this analysis!'

At the stage that I am describing, the patient had supplied material of an indirect kind so that I could know that she was probably feeling something. I was able to say that she had been feeling feelings, and she had been experiencing these gradually fading, according to her pattern, a pattern which made her despair. The feelings were sexual and female. They did not show clinically.

Here in the transference was myself (nearly) being the cause now of her female sexuality fizzling out; when this was properly stated we had an example in the present of what had happened to her innumerable times. In her case (to simplify for the sake of description) there was a father who at first was scarcely ever present, and then when he came to her home when she was a little girl he did not want his daughter's female self, and had nothing to give by way of male stimulus.

Now, emptiness is a prerequisite for eagerness to gather in. Primary emptiness simply means: before starting to fill up. A considerable maturity is needed for this state to be meaningful.

Emptiness occurring in a treatment is a state that the patient is trying to experience, a past state that cannot be remembered except by being experienced for the first time now.

In practice, the difficulty is that the patient fears the awfulness of emptiness, and in defence

will organize a controlled emptiness by not eating or not learning, or else will ruthlessly fill up by a greediness which is compulsive and which feels mad. When the patient can reach to emptiness itself and tolerate this state because of dependence on the auxiliary ego of the analyst, then, taking in can start up as a pleasurable function; here can begin eating that is not a function dissociated (or split off) as part of the personality; also it is in this way that some of our patients who cannot learn can begin to learn pleurably.

The basis of all learning (as well as of eating) is emptiness. But if emptiness was not experienced as such at the beginning, then it turns up as a state that is feared, yet compulsively sought after.

#### *Non-existence*

The search for personal non-existence can be examined in the same way. It will be found that non-existence here is part of a defence. Personal existence is represented by the projection elements, and the person is making an attempt to project everything that could be personal. This can be a relatively sophisticated defence, and the aim is to avoid responsibility (at the depressive position) or to avoid persecution (at what I would call the stage of self-assertion, i.e. the stage of *I am* with the inherent implication *I repudiate everything that is not me*). It is convenient here to use in illustration the childhood game of 'I'm the

King of the Castle—You're the Dirty Rascal'.

In the religions this idea can appear in the concept of oneness with God or with the Universe. It is possible to see this defence being negated in existentialist writings and teachings, in which existing is made into a cult, in an attempt to counter the personal tendency towards a non-existence that is part of an organized defence.

There can be a positive element in all this, that is, an element that is not a defence. It can be said that *only out of non-existence can existence start*. It is surprising how early (even before birth, certainly during the birth process) awareness of a premature ego can be mobilized. But the individual cannot develop from an ego root if this is divorced from psychosomatic experience and from primary narcissism. It is just here that begins the intellectualization of the ego-functions. It can be noted here that all this is a long distance in time prior to the establishment of anything that could usefully be called the self.

#### SUMMARY

I have attempted to show that fear of breakdown can be a fear of a past event that has not yet been experienced. The need to experience it is equivalent to a need to remember in terms of the analysis of psychoneurotics.

This idea can be applied to other allied fears, and I have mentioned the fear of death and the search for emptiness.

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*Editorial Note.* Mrs Clare Winnicott has commented on the paper printed above, as follows:

This particular paper was offered for posthumous publication because it was written shortly before Donald Winnicott's death and it contains a first condensed statement based on current clinical work. The formulation of these clinical findings around the central idea contained in the paper was a significant experience. Something surfaced from the depths of clinical involvement into conscious grasp and produced a new orien-

tation to a whole area of clinical practice. It was the intention to study further some of the specific topics in the paper, and to write about them in greater detail, but time did not allow this work to be done.

Because my husband would have wished to be associated with the publication of this new Journal, I am very glad that the Editor was willing to include one of his papers in this first issue of the *International Review of Psycho-Analysis*.

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