DEPENDENCE AND DEPENDABILITY: WINNICOTT IN A CULTURE OF SYMPTOM INTOLERANCE

ADRIAN SUTTON

SUMMARY

Themes relating to states of dependence and the impact of these on the dependent person, those upon whom they are dependent and the framework within which their lives are lived are central to Winnicott's work. Conscious and unconscious conflicts arising from these can have powerful effects on the emergent structure of the personality, relationships and the structures of society. Within this context Winnicott was particularly concerned with presentations of physical symptoms and the responses to them. Clinical material is presented where his ideas shaped the overall approach and to illustrate how adaptations of his techniques were used in response to the child patient, her family and the available resources of the therapist. This material is particularly noteworthy for its use of postal communications and the use of the imaginations of the therapist and patient.

The material is used to explore issues of dependence, dependability and interdependence in relation to psychosomatic presentations. The latter themes are expanded to reflect on wider societal issues as pathological responses to conflicts about dependence. The conclusion is that Winnicott's constructs are crucial in a climate of reaction against dependence as a fundamental component of the human condition.

INTRODUCTION

Winnicott addressed subjects across the range of psychoanalysis, psychotherapy and child psychiatry through to social welfare and the nature of culture. Although he presented many formulations and constructs, he did not propose his own systematic theoretical framework. Rather, within the overall system of psychoanalysis, he described constellations relating to development, relationships, the structure and functioning of the psyche, and clinical technique in the varying contexts with which he was concerned. Thus, his concepts and ideas can be met in many places, sometimes like an everyday part of the scenery, sometimes like a familiar friend in unfamiliar territory. In some instances they can feel to be easily accessible but at other times they stay somehow just out of reach. This paper focuses on Winnicott's contribution to understanding the significance and the importance of respecting symptoms, linking these to issues of dependence and finally reflecting on the wider relationship of these to cultural conflicts with regards to dependence. The clinical material used is not from a formal psychotherapy or psychoanalysis. It is from general child psychiatric practice using a psychoanalytic framework but within which, for this author, the most immediately identifiable 'architectural' features and sustaining influences, the matrix, were the writings of Winnicott.

SYMPTOMS, SIGNS AND DIAGNOSIS

Symptoms are the starting place for the practice of medicine. The Concise Oxford Dictionary (COD) defines a symptom as a 'perceptible change in the body or its function indicating injury or disease'. The patient's presenting symptoms may be expanded in response to the physician's enquiries relating directly to them and in relation to his or her general health: physical signs may be identified at examination, and perhaps further information may be sought through laboratory tests and investigations. On the basis of this process, and in all likelihood during this process, a list of possible causes (the differential diagnosis) will be formulated. This forms the basis for understanding what may or may not be possible by way of treatment and the range of likely outcome. And throughout this process, of course, there are people having experiences, living their lives.

As a physician, Winnicott was interested in the significance accorded to symptoms in the realms of both physical and mental health. He was particularly concerned about the issues which arise at the meeting-place of these in the area referred to as 'psychosomatics'.

In 1953 Winnicott presented the Presidential address to the Paediatric section of the Royal Society of Medicine in London. He chose as his title 'Symptom Tolerance in Paediatrics: a case history'. This is not one of his most often quoted papers but it has been an almost constant companion for me in thinking about symptoms and illness and in the struggle to understand more of the experience of dysfunction whether or not such dysfunction is grasped with the title of 'illness'. The 'experience' being referred to here is both that of the person with the dysfunction and also the people with whom they have relationships, whether they be in personal or professional capacities.

1 This paper was originally presented at a conference entitled 'Winnicott: a name for the archives or for the twenty first century', organised jointly by the Winnicott Centre, Manchester and the North West Institute of Dynamic Psychotherapy, January 2000.
WINNICOTT IN A CULTURE OF SYMPTOM INTOLERANCE

SYMPTOM TOLERANCE IN PAEDIATRICS

In his address to the Royal Society of Medicine, Winnicott summarised his view of symptoms as indicators of a disorder which must be understood in their full context: ‘...The psychiatrist is therefore not a symptom-curer; he recognises the symptom as an SOS call that justifies a full investigation of the history of the child’s emotional development, relative to the environment and to the culture. Treatment is directed towards relieving the child of the need to send out the SOS.’ (p101-2)

The case he presented is of a young boy, Philip, who developed behavioural difficulties which were on the verge of leading to expulsion from school. The intervention by Winnicott led to what was effectively a year’s sick leave rather than expulsion. He was given leave to be sick in order to get better, a year without having to function at the level which would ordinarily be expected of a child of his age. During this year the boy experienced many symptoms and displayed many signs of disorder.

Winnicott reflects on the issue of symptom-focussed approaches which do not take an holistic, developmental perspective

...In most cases the cure of the symptoms does no harm, and when a cure could do harm the child usually manages, through unconscious processes either to resist cure or to adopt an alternative SOS sign, one that produces transfer to another type of clinic. (p103)

The case is of further interest because it was a situation in which neither psychotherapy nor psychoanalysis was possible. In typically provocative style, Winnicott also challenges what might be considered his own ‘establishment’ with the comment

The loss is simply that the child fails to gain insight, and this is by no means always a serious loss. (p115)

More recent work would appear to lend support to this contention (Hurry 1998).

DEPENDENCE AND INDEPENDENCE

Winnicott describes how Philip regressed and required

...that which is the right of every infant at the start, a period in which it is natural for the environment to make active adaptation to his needs.

Philip was relieved of the responsibility to manage himself within the range usually expected of a child of his age: this included responsibility for sphincter control (nocturnal enuresis developed) which provided Winnicott’s specific link to physical symptoms for his paediatric audience. Philip became

A CHILD, HER FAMILY AND THEIR MEDICAL WORLD

...withdrawn and dependent’ and within this was able, safely, to be ill in order to get better.

The occurrence of symptoms may cause little disruption to a person in their everyday life or minor illnesses may lead to the need to be relieved of some responsibilities, to be ‘off sick’. More serious situations may require the help of others. The ill person may need them to fulfil certain functions and become dependent on these others: in extremis, this may extend to his/her vital functions being maintained by external means.

Groddeck, a contemporary of Freud’s, proposed a construct of the ‘It’ (1920). In his view, illness occurred under the ‘It’s’ influence as a mechanism to manage particular conflicts. He saw illness specifically as a retreat from conflicts inherent in independence, a search for dependability in the outside world because what it needed was unavailable internally: the ‘It’ issues the order ‘Retreat from life, stay in bed, be a child and you will find a mother who will care for you.’ (1925)

Dependence is usually contrasted with independence. In fact, Winnicott (1963) himself appeared to do just this in the title of a paper ‘From Dependence to Independence in the Development of the Individual’. However, this simple dichotomy is at best of limited usefulness and potentially a false distinction with profoundly adverse effects. Winnicott acknowledged this in the text of his paper:

Independence is never absolute. The healthy individual does not become isolated, but becomes related to the environment in such a way that the individual and the environment can be said to be interdependent.

This has major ramifications for the structure which is developed to respond or not respond to those who feel that what they depend upon lies outside their own resources, including when this occurs at times of illness.

The clinical material presented in this paper could direct us towards many areas of Winnicott’s writing. However, its particular focus is consideration of some present day dilemmas relating to disrupted dependence and dependability.
formulated. This is a very common type of presentation in Child Psychiatry although most illnesses of this type are not usually as persistent as hers. Ultimately Vanessa herself will formulate for us something of the developmental and dynamic struggle of her illness.

Limitations were imposed upon the extent of clinical contact by a mixture of Vanessa living some distance away and the resources available to treat her. The material therefore does not derive from a formal psychotherapy but rather from an approach which some might call ‘supportive psychotherapy’. However, this does not indicate the breadth of therapist activity which was involved. The process was one in which individual consultations with Vanessa, joint meetings with her parents, meetings with her parents separately and family sessions alongside close liaison with her paediatrician and other doctors all took place. An additional element, communication between Vanessa and myself by letter was also introduced. Perhaps the term ‘psychoanalytically-informed therapeutic case-management’ best captures the spirit of negotiating and working with the internal and external world. It is only possible to present a very particular area of the work but this should not be taken as an indication that these other areas were not as fundamentally important in being of use to Vanessa. The material covers contact over a period of seven years.

The Initial contact

Vanessa was eleven years old when I first saw her. Her recurrent illness took the form of pains which were intermittently residing in her ears and throat. She had been unwell for four years and had missed considerable schooling. Vanessa’s parents were at a loss as to how best to respond. When they saw her suffering how could they know whether this might indicate the need for her to be off school, sick, or a need for their help in getting her across the threshold into school to face and master anxieties which might be contributing to, or causing, the physical complaints? The main burden of this task fell to her mother, who needed to maintain her availability and accessibility to Vanessa at a very high level. There were periods of extended absence from school. At other times, it may have been difficult to decide whether Vanessa could manage in school on a particular day or for a full day and mother would need to be readily available (it is important to emphasise that symptoms were not only related to school-days). At assessment, it was impossible for them to live a life which was not ruled by anxiety about Vanessa’s physical well-being.

In her individual consultation, Vanessa was amenable and pleasant. It was not possible to delineate any specific problems beyond the physical complaints and the impact of these on her life. No lines of inquiry immediately presented themselves from our conversation or from her use of any of the materials provided. Feeling at something of a loss and not knowing quite what else to do, I decided to see if Winnicott’s technique of the ‘Squiggle’ would be of use.

In his ‘Symptom Tolerance’ paper Winnicott described the ‘Squiggle technique’ thus:

It is a game in which I first make a squiggle and [the child] turns it into something, and then he makes a squiggle and I turn it into something.

Winnicott was able to use it both diagnostically and therapeutically. However, it is not entirely unreasonable to describe it as an unstandardised, unsystematised projective and therapeutic technique which contains the danger of telling us as much, if not more, about the tester as about the tested without either party necessarily being aware of it. My own position is that, even without Winnicott’s particular gifts, used with circumspection and reflection, it may contribute to the process of exploration and enhance diagnostic and therapeutic possibilities.

Vanessa took readily to the Squiggle Game. However, a pattern arose in which she would be able to put a description or narrative to her picture but would come to a stop at a point where nothing more came to mind other than there being something dangerous. This was not accompanied by any overt signs of anxiety or fear for Vanessa.

Two points were of particular note in the family history. The family had moved house shortly after Vanessa’s birth, leaving behind a close-knit extended family and network of friends. This was an extremely difficult time for mother. She had suffered from urinary-tract infections during the pregnancy and these problems had continued in the puerperium. With the upheaval and illness came a period of postnatal depression which resolved without outside intervention. Secondly, Vanessa was not reported as having any unusual degree of physical symptomatology until she was 7 years old: nor had there been any developmental concerns. However, she then suffered symptoms which were diagnosed as urinary-tract infections; She had recurrent illnesses of this form which were then followed by symptoms in other areas of the body with different diagnoses. Subsequent review of the microbiological findings during the period of my involvement called into doubt the diagnosis of bacterial infection as the cause of the abdominal and urinary symptoms which Vanessa had experienced.

The unfolding picture

During my further consultations with Vanessa and her parents, I regularly found myself experiencing powerful feelings of tiredness. In fact, sometimes I would be struggling to stay awake let alone think clearly. It took some time to register in me that this experience actually occurred not only with Vanessa but
also with other patients who had comparable presenting problems. This made it possible to consider my experience as a clinical sign, i.e. a countertransference response. Realisation of this was followed by cessation of this extraordinarily powerful devitalising and mind-deadening experience. It became possible to maintain myself as an alive, thinking person in consultations and for the possibility of new thinking to occur in me about Vanessa and the other children like her.

**Making use of the countertransference**

There were two important elements to the use of my own state of mind as clinical information. In the absence of any other identifiable variable, the change in my ability to function provided support for the hypothesis that it was in fact a countertransference phenomenon. Secondly, the time it took me to achieve a state where I had this thought was a process which needed further investigation.

Examining my countertransference is a routine part of my clinical practice, yet this ability seemed to have become dormant in me in my consultations with Vanessa. I lost not only the power to examine myself i.e. to experience and think simultaneously, but also a normally functioning part of myself which could register that something unusual which needed to be taken notice of was happening. I did not 'have it in me' or at least 'couldn't find it in myself'. The challenge was to try and avoid losing all sense of myself as a functioning human being. This was, I believed, a communication into me of Vanessa's own experience.

**Stepping into the unknown.**

Having reassembled myself, I took a new path with Vanessa. I explained that neither I, nor the other doctors, had a name for her illness although what we did know was that there was no indication of anything dangerous going on in her body. I suggested that in the absence of us being able to provide a name, she should think of one. Thus, finally, we arrived at a diagnosis of 'Bert'.

Vanessa took to this approach and was able to play with the idea with me. I asked where Bert would live if he could not live in her ears or throat. After some consideration she spontaneously said 'I need to find a place in my heart for him.' Vanessa and I then attempted to get to know Bert. We did this during direct contact in subsequent consultations and by correspondence. We attempted to compile a life history of Bert, to work out what he might look like and even to 'introduce' him to Vanessa's still-cherished transitional object, Kenneth, a soft toy animal. The examples which follow are taken from some correspondence in our second year of contact.
So, Bert was neither born nor invented but created out of one of your pains! What on earth does a creature like that look like? This is going to be extremely important to know because how on earth would Kenneth know what to look for if he did decide to go in search of him?

The problem is that neither you, me, your Mum and Dad, nor any of the doctors in the hospital have ever actually seen him — so, how can we get a proper description? We are going to have to work on what the police would call ‘an artist’s impression’. It’s more difficult for us though because we’ve only got your inside-feelings to go on and not your eyesight or mine. I’d like you to write down what different bits of him feel like and then draw a picture of him. By the way, how do you know it’s a ‘he’ not a ‘she’?

It’s also clear that we mustn’t rush Bert and Kenneth into a meeting – it sounds like they both want you all to themselves – one knows you inside: one knows you outside: it’s going to take time for them to learn that they can both know you inside-out without losing you to anyone else. They are going to have to learn this from you and it’s going to take time. So, they mustn’t meet yet otherwise there will be fireworks! You’ll need to work out how to teach them that it’s safe to share (it might even be fun); can you start writing about it?...

Best wishes,
Dr Sutton

A slippery slope?

The subsequent material describes specific episodes from contact over the next five years. In between these, there were difficulties which were managed mainly by Vanessa and her mother without major input by myself. The overall pattern was one of progress towards integration in psychodynamic terms, with this manifest across the breadth of functioning.

Bert was a slippery character. Not long after the above correspondence, having ‘identified’ her left big toe as his place of residence when not living in (ie causing pain in) her ears and throat, Vanessa arrived for her next consultation on crutches. There had been an accident. She had dropped a mirror on her left foot: walking awkwardly as a result; she had slipped, badly sprained her ankle, and this had led to the provision of crutches. Active work with the parents and professional system was then also needed to ensure that unhelpful medical activity did not occur in relation to these new symptoms. The tightrope to be walked was to neither deny the pain of the identifiable injury nor unhelpfully to ‘feed’ the psychopathology driving her chronic difficulties.

The achievement of neurosis

Despite intermittent periods of illness, Vanessa was able to regain considerable ground in her education. There was recognition that she was behind her peers in certain areas. This was attributed by the school to her extended absences. However, my process of contact with her had made me feel she had specific areas of difficulty in reading and writing which had gone unrecognised because of this assumption. Formal assessment confirmed my clinical impression. Her parents were able to arrange extra help for Vanessa with a tutor who made a good relationship with her.

When she was 16, there was an episode of severe and sudden onset of new symptoms of a different quality. These resulted in neurological investigations. By close liaison with her parents, her paediatrician and the neurologist, it was possible to ensure that these investigations did not extend beyond necessity and usefulness. Through the period of recovery from this episode over a number of weeks, it remained puzzling as to “Why now?” and “Why these symptoms?” But ultimately it was possible to formulate an explanation which seemed sufficient.

Vanessa had been on a trip with her mother and grandmother when the sudden onset of symptoms had occurred. Her grandmother had recently experienced an acute psychological trauma. On this trip the grandmother was returning, for the first time, to a place with particular associations to the trauma. Vanessa had momentarily lost sight of her grandmother, and her physical symptoms had developed immediately. The specific symptoms related both to the nature of the original trauma which her grandmother had experienced and to the immediate situation, although at the point of experiencing the symptoms Vanessa was not conscious of any links between immediate and past events, nor their significance to herself and in her relationships.

Analysing the immediate situation in the context of our overall work together provided an explanation and understanding to both Vanessa and me of why she had experienced these symptoms at that point. Direct therapeutic gain followed from this process. The diffuse experience of ‘dangerousness’ portrayed in the Squiggle game and present in her usual physical symptoms and loss of function had been replaced by a more focused process for which we could find words. This was a very different constellation from the way problems had previously presented. In contrast to the pattern of diffuse symptoms in her previous psychosomatic presentations, a definable hysterical conversion illness episode had occurred. The underlying defence mechanisms required to produce these are very different. In the former case, the mechanisms are those whose consequences, or perhaps even aims, are to obliterate experience, whilst in the latter they are of managing the internal conflict arising out of experience in an attempt to negotiate with both external reality and internal unconscious phantasy. Developmentally the first belongs to an earlier stage of life – Vanessa had achieved the ability to have a neurosis.
Moving towards an altered locus of dependability

At the age of 18, after a few months without any correspondence, Vanessa wrote to me again.

Dear Dr Sutton

Why is it that when you should be happy and care free that almost depression glides over your whole life?

I have got my results and now I am at the university of my choice, to do the course I have picked. I have a fantastic Boyfriend and some brilliant mates. I am working and therefore earning money with great employers.

But it seems as if there is something missing. I’m on autopilot and it seems like I’m not living my own life, physically it does with the tiredness after working for five hours, but mentally it is somebody else doing it. It’s not me. I guess the truth is it’s Bert, which makes me realise that I will be alright in a few days, and my bubbly personality will shine but in the mean time I will continue to operate under a dark cloud.

The strongest feeling inside me is to escape, go away, think and most importantly relax, which I feel physically I haven’t done in months, what with school, then work.

The last I wrote to you I spoke about a feeling of control, well that has gone for the moment. I lost hold of it and am now dreaming about retrieving it.

I am at works becon [heck and] call and the rest of the time I have to divide between Dave (my boyfriend) and my mates. Where am I supposed to find time to myself ...

Whilst writing this letter I am listening to the Alanis Morissette album, I don’t know if you have ever heard any of her but personally I believe the lyrics are surprisingly relevant in reality and life as I am finding it. In one song called Perfect some of the lyrics are:

[']Don’t forget to keep that smile on your face. What’s the problem...why are you crying? [']

I guess they apply to most people. I know I will get through this bleak period as I have survived the last years of my life. But hey a smile doesn’t have to be present ['pleasant' crossed out] constantly on my face.

It’s wired [weird] I can hardly remember what I wrote at the beginning of this letter. But what I do know is that I feel better for writing. In case you hadn’t realised this is one of the first times I have been absolutely honest about my feelings to you. And as Bob Dylan sang in the first few lines of all along the watch tower

There must be someway out of here
There’s so much confusion
I can’t get no relief...

I replied:

Dear Vanessa

It was lovely to receive your letter. That may sound a bit strange when it was about feeling sad and empty. But it was a beautiful letter because of how clearly you explained...
reliance on identificatory processes for decision-making. Her mother had always been open in seeking assistance in thinking about how to respond to Vanessa’s symptoms, and made explicit her anxiety. However, there was then a period during which Vanessa had problems with her elbow. I was very struck, in a consultation with them together, that her mother was confident and not anxious about what to do for Vanessa. I commented on this and asked if she knew what made the difference. She was able to reply without any hesitation. She knew exactly what to do because she had had this problem herself and knew exactly what it was like.

Perhaps Groddeck’s statement can be adapted:

Retreat from life, stay in bed, be a child and you will find a mother who may find in her the mother who will care for you (1925).

INDEPENDENCE OR LOCATING DEPENDABILITY?

Vanessa’s periods of physical symptomatology recurrently placed her in a state more dependent on her mother. She had often needed her mother to be the judge of her physical capabilities and her ability to manage what would be the ordinarily expectable range of activity for someone of her age – her peer-group would have been far more likely to have been in conflict with parental authority about many of these things. It also meant they spent more time in each other’s company.

Through the above story, Vanessa is moving from a state of unusual dependence for her chronological age and through the developmental phase of adolescence. Definitions of adolescence may often be based on the idea that this is a period during which we move from dependence to independence. However, it is really the phase during which we move from childhood forms of dependence and interdependence to adult forms of dependence and interdependence. We first stand on our own two feet, suspended from the dependability of our parents’ hands: physical development then allows us to find that dependability within our own bodies. To the extent of our inherent potential and our acquired limitations, in conjunction with properly adapted care, we are able to find more and more of that dependability within. Winnicott encapsulates this in the title of one of his books of collected papers ‘The Maturational Processes and the Facilitating Environment’.

The crucial issue is that we are able to make realistic judgements about what it is possible to find in ourselves that we can depend upon and what it is that we need to find in others. Some of these judgements may be relatively easy or clear-cut. But the very judgements we have to make rely on us having a healthily developed sense of our ability to make judgements. How does this process occur? In addition to individual developmental factors and processes within relationships, it also relies on the culture to which we belong. At one time, in certain illnesses which are now treatable, it would have been entirely appropriate to put the future of the patient in the hands of God. Given the state of knowing and not-knowing that pertained, there may perhaps have been a very powerful emotional container present in handing an outcome over to a higher authority. But if helplessness and fatalism in the face of symptoms are taken as total guiding principles, no development can occur. Advances lie in the area between expectation and aspiration wherein that which is demanded or longed for, may come to be.

GAP OR SPACE?

To return more directly to the issues raised in the question of physical symptomatology, the problem, then, is one of whether or not these experiences can be known and managed. The eminent scientist Patrick Wall (1999) wrote the book ‘Pain: the science of suffering’ whilst living with terminal cancer. He stated:

Coping is not ignoring. In fact, it is the opposite. ... pain persists but no longer demands emergency responses. It is not a catastrophe signalling impending annihilation...Coping is the beginning of a series of steps that give a sense of understanding and a type of control.

The psychoanalyst McDougall (1989) described the predicament of patients with psychosomatic problems because words cannot serve a ‘coping function’ in Wall’s sense. My own work in this arena suggests that important contributors in such presentations are underlying conflicts in relation to tolerating ‘not-knowing’ or ‘not-being-known’ in psychical states which were originally experienced as even more than life-threatening – in fact, as a fate worse than death (paper in preparation). These states relate to Bion’s (1957) ‘nameless dread’. The preverbal origins mean that the usual intellectual means of containing, understanding and communicating about them are not available to the patient, the parent or the professional. Further, the use of the physical is the means both of contending with and defending against such mental states.

We can grapple with this if we consider the difference between a gap and a space. To return to the Concise Oxford Dictionary, ‘gap...unfilled space or interval, blank, break in continuity’ [author’s italics] and ‘space...continuous extension viewed with or without reference to the existence of objects within it’. O’Shaughnessy (1964) proposed the concept of the Absent Object - a non-providing object who is not actually present but who is experienced as present in a persecutory form because of relief not being obtained. In the type of psychosomatic presentation I have described, instead of the experience of the Absent Object, the body serves to fill this gap as if it is the other without not being of the self. There is a failure to develop adequately what Winnicott came to call the ‘transitional space’ - a space where experience can be explored without fear for or of the objects within it.
So, who is 'Bert'? 

Winnicott formulated the constructs of the 'True Self' and 'False Self' (1960) to illustrate the internal processes which may flow from very early disruptions to the experience of the external world as dependable in a form which the infant ego can manage. These constructs can provide essential assistance in the struggle to help in alleviating psychosomatic presentations.

However, they were actually presaged by Groddeck (1923) in his formulation of the 'It'. In The Meaning of Illness' he provides a firm basis for respecting the struggle for health which is contained in the symptom of an illness. The following extract captures the spirit of the correspondence between Vanessa and myself and the nature of 'Bert':

Yet the person who does the interpreting should no longer be the physician: only the patient himself can supply the necessary information about his It and its intentions and activities. For every It has its own thought processes and ideas concerning symbolic meanings. The role of the therapist is restricted to that of making the recalcitrant It talk and even more significantly, being as open as possible in order to allow the patient's It the least possible excuse for mistrusting him (p.201).

Vanessa and I never did get a very clear picture of Bert. We were able to know when he was around. We certainly understood when and how he made his presence felt. If a formal psychotherapy or psychoanalysis had been possible we would probably be in a position to give a much fuller answer. However, I believe some preliminary formulations can be made from the work with Vanessa and comparable findings with children presenting with similar difficulties.

Bert can be understood as an encapsulated expression of Groddeck's 'It' or Winnicott's 'True Self'. His characteristics relate to a failure to achieve a state where the elements he represents could find a manageable place in the transitional space. The possibility of these being contained and processed within the early infant-mother dyad was therefore not available. Instead, these elements remained in a form which needed to be met in the arena of the body and its care rather than progressing through to symbolic expression. Bert is the manifestation both of need which must be expressed and the defence against awareness of the arousal and threat experienced in that state. The emergence of symptoms diagnosed as urinary-tract infection provided a rendezvous and a link for mother and daughter at that earliest time of their life together when we know mother was experiencing major difficulties, and for both to find the mother who was needed. What could be known about Bert will have been further shaped by the other available relationships including those within the family and those with professionals. His 'creation' in the therapeutic relationship is the attempt to bring him into the Transitional Area of functioning, where the most dreadful things can be done and experienced in safety. Ultimately, instead of a physical experience of pain, Bert became for Vanessa an emotional state which could be known to be something which was truly a part of herself rather than something living independently inside her. In addition, he could be a part of her which would need to be accommodated and which could be adapted to for a period of time but whom she could know was not going to rule her life forever.

CULTURES OF DEPENDENCE AND DEPENDABILITY

In my work with Vanessa, I felt Winnicott at my elbow, a support and a guide offering an opportunity for creative spontaneity and a buffer against destructive impulsiveness or mindless inactivity. His use extends beyond the immediacy of direct clinical work to the links he makes between individual and cultural experience.

Winnicott placed great importance on the concept of 'culture', seeing its roots in the experience of the earliest relationships. Abram (1996) gives an invaluable entry point to this aspect of his work.

The actual customs, language, and so on that relate to each specific society emerge out of this early culture...the handing-down from one generation to the next, not just of the traditions and customs of a given society, but of their symbolic and emotional meaning (109-10).

The institutions of our societies are one element of our culture. During his life, Winnicott saw the establishment of the welfare state but did not live to see the rationalisation, some would say the dismantling, of key aspects of this during the last quarter of the century. The aspiration for universality of provision which contained the expectation that it could, should and would come into existence has been challenged even by members of groups previously regarded as its champions. The sociologist Richard Sennett (1998) described the process thus:

The attack on the welfare state...treats those who are dependent on the state with the suspicion that they are social parasites, rather than truly helpless. ...The ideology of social parasitism is a powerful disciplinary tool in the workplace; the worker wants to show he or she is not feeding off the labors of others.

This would seem to be the sociological equivalent of what Winnicott described in 'Symptom Tolerance' as 'a moral attitude'. This position can be contrasted with a stance which sees symptoms and neediness as SOS signals rather than interpreting them only in relation to the degree of unwelcome impingement on others.
WINNICOTT IN A CULTURE OF SYMPTOM INTOLERANCE

At an everyday clinical level in Child Psychiatry, this is manifest in many referrals of children because they are not manageable. The implicit or explicit request is to make them, for example, manageable in the classroom because they are on the verge of exclusion or expulsion from school. All too often assessment of these children reveals serious problems in many areas of their development and functioning such that it is actually unreasonable to expect them to be able to manage in a setting whose demands are beyond their abilities. The classroom setting requires the dependable presence of a range of abilities in individuals alongside adaptations in environmental provision which can reasonably expect to meet the range of need likely to occur in children of a particular age.

The need for a ‘fit’ between ability and demand is no less true of other stages of life, although there will be variations in the nature and degree of this. Instead of a culture which sets dependence and independence as value-loaded polarities what is required is one which accepts that what can be depended upon may lie within or outside an individual and that this is a dynamic state within and between individuals. Sennett (1998) described it thus:

None of these repudiations of dependence as shameful, however, promote strong bonds of sharing. ... Almost without thinking we accept contrast between a weak, dependent self and a strong, independent self. But like the contrast between success and failure, this opposition flattens out reality (p.139).

He cites Bowlby

... [a] healthily self-reliant person [is capable of depending on] others when occasion demands and to know on whom it is appropriate to rely and he adds

In intimate relations, the fear of becoming dependent on someone else is a failure to trust him or her; instead one’s defences rule.

Winnicott captures the nature of dependence and interdependence as a basic part of the Human Condition in which a single transaction may fulfil or fail to fulfil need at many different levels of being. He provides us with a framework which conceptualises this and which is available as a tool in the complicated task of moving between the intrapsychic, the interpersonal and the collective whilst still according a full appreciation of both the conscious and unconscious. In a context where full psychoanalytic treatment is not available or not desired, he provides a bridge which can accept that insight may not be the only acceptable end-point of a therapeutic involvement. In a comparable way, living with ‘not-knowing’ in terms of tolerating his or her inability to provide a comprehensive formulation can be as crucial for the therapist as being able properly to appraise their usefulness to the patient. It should not be confused with simple complacency in the face of ignorance. The

thrust of this paper is to illustrate the continuing dependability its author finds in Winnicott’s formulations concerning the meaning of symptoms and express a view that these are of even greater importance now in a culture which confuses maturation with independence, and conceptualises independence in moral terms.

The COD tells us a symptom is a ‘sign or token of the existence of something’. The clinical material presented in this paper highlights how symptoms may in fact be a sign or token of the existence of someone. Survival requires the development of symptoms in order to seek solutions to whatever needs to be brought to our notice. Along with this, there needs to develop an ability to discriminate between what needs to be responded to by ‘doing’ and what by simply tolerating in the knowledge that we will carry on being. This is a life-long task. The roots of such tolerance and intolerance lie in the earliest helpful and unhelpful disruptions of dependence.

REFERENCES


I am indebted to Professor Robert Boyd, the paediatrician involved in Vanessa’s care, for his encouragement, interest and insight which facilitated the development of my clinical work and formulations in this arena.

Adrian Sutton
The Winnicott Centre, Manchester, M13 0JE.
Tel: 0161 248 9494   Fax: 0161 225 9338