THE MATURATIONAL PROCESSES AND THE FACILITATING ENVIRONMENT

Studies in the Theory of Emotional Development

By

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EDITORIAL NOTE

This volume brings together Dr Winnicott's published and unpublished papers on psycho-analysis and child development during the period 1957–1963. The series of papers presented here complements those published in *Collected Papers: Through Paediatrics to Psycho-Analysis* (London: Tavistock Publications, 1958).

There are two bibliographies at the end. The first includes all the books and papers referred to in the text. The second gives a list of Dr Winnicott's writings from 1926 to 1964.

In order that the text itself shall not be encumbered with too many cross-references and footnotes the inter-relationships of the themes and concepts discussed in Dr Winnicott's papers are provided in the index. The major themes are also broken down into sub-categories and indexed in such a way that the various implications and connotations of an idea become readily available to the reader. The basic concepts of Freud are indexed in relation to Dr Winnicott's discussions or elaborations of them. Quite often Dr Winnicott has taken a Freudian concept as his given frame of reference but has not discussed it as such, and it is intended that the index should in part remedy this by pointing out the links between Dr Winnicott's ideas and those of Freud.

M. MASUD R. KHAN
Associate Editor

INTRODUCTION

The main theme of these collected papers is the carrying back of the application of Freud's theories to infancy. Freud showed us that psycho-neurosis has its point of origin in the interpersonal relationships of the first maturity, belonging to the toddler age. I have played a part in the exploration of the idea that mental hospital disorders relate to failures of development in infancy. Schizophrenic illness in this way shows up as the *negative* of processes that can be traced in detail as the *positive* processes of maturation in the infancy and early childhood of the individual.

Dependence in early infancy is a fact, and in these papers I have tried to take dependence right into the theory of personality growth. Ego-psychology only makes sense if based firmly on the fact of dependence, and on the study of infancy as well as on the study of primitive mental mechanisms and psychic processes.

The beginning of ego emergence entails at first an almost absolute dependence on the supportive ego of the mother-figure and on her carefully graduated failure of adaptation. This is part of what I have called 'good-enough mothering'; in this way the environment takes its place among the other essential features of dependence, within which the infant is developing and is employing primitive mental mechanisms.

One aspect of the disturbance of ego emergence produced by environmental failure is the dissociation that is seen in the 'borderline case' in terms of the true and the false selves. I have developed this theme in my own way, seeing the representatives of this dissociation in healthy persons and in healthy living (private self reserved for intimacies, and public self adapted for socialization), and also examining the pathology of the same condition. At the extreme of illness I see the true self as a potentiality, hidden and preserved by the compliant false self, which latter is then a defence organization that is based on the various functions of the ego apparatus and on self-caretaking techniques. This relates to the concept of the observing ego.

Following up the idea of absolute dependence in earliest infancy I put forward a new way of looking at classification. My intention here is not so much to label personality types as to promote thinking and research into those aspects of the psychoanalytic technique which relate to meeting the patient's need in terms of dependence in the analytic relationship and situation.

The origin of the antisocial tendency is discussed. It is postulated that the antisocial tendency is a reaction to *deprivation*, not a result of *privation*; in this way the antisocial tendency belongs to the stage of relative (not absolute) dependence. This point of origin of the antisocial tendency in a child's development may even be in latency, when the child's ego has established autonomy and now therefore the child can be traumatized instead of distorted in regard to ego-functioning.

As a corollary to all this, the more psychotic disorders are seen to be closely related to environmental factors, whereas psychoneurosis is more essentially natural, a result of personal conflict, and not to be avoided by satisfactory nurture. It is further discussed how it is in the treatment of borderline cases that these new considerations find practical application, and indeed such treatments provide the most fruitful and accurate data for the understanding of infancy and of the dependent infant.

ACKNOWLEDGEMENTS

First I wish to acknowledge my debt to my psycho-analytic colleagues. I have grown up as a member of this group, and after so many years of inter-relating it is now impossible for me to know what I have learned and what I have contributed. The writings of any one of us must be to some extent plagiaristic. Nevertheless I think we do not copy; we work and observe and think and discover, even if it can be shown that what we discover has been discovered before.

I have found great value in travelling abroad and in discussing my ideas with those who work in analytic, psychiatric, paediatric and educational settings, and in society groupings that differ from those that obtain in London.

I wish to thank my secretary Mrs Joyce Coles whose accurate work has been an important part of each of these papers at its original coming to life. I am also grateful to Miss Ann Hutchinson who has prepared the papers for publication.

Lastly, I thank Mr Masud Khan, who has provided the drive which has resulted in the publication of this book. Mr Khan has given a great deal of his time to the work of editing. He has also made innumerable valuable minor suggestions, most of which I have accepted. He is responsible for my gradually coming to see the relationship of my work to that of other analysts, past and present. In particular I am grateful to him for his preparation of the index.

D. W. WINNICOTT

Part One

PAPERS ON DEVELOPMENT

1

PSYCHO-ANALYSIS AND THE SENSE OF GUILT[1]

(1958)

In this lecture I shall reach to no more profound statement than that of Burke, who wrote two hundred years ago that guilt resides in the intention. The intuitive flashes of the great, however, and even the elaborate constructs of poets and philosophers, are lacking in clinical applicability; psycho-analysis has already made available for sociology and for individual therapy much that was previously locked up in remarks like this one of Burke.

A psycho-analyst comes to the subject of guilt as one who is in the habit of thinking in terms of growth, in terms of the evolution of the human individual, the individual as a person, and in relation to the environment. The study of the sense of guilt implies for the analyst a study of individual emotional growth. Ordinarily, guilt-feeling is thought of as something that results from religious or moral teaching. Here I shall attempt to study guilt-feeling, not as a thing to be inculcated, but as an aspect of the development of the human individual. Cultural influences are of course important, vitally important; but these cultural influences can themselves be studied as an overlap of innumerable personal patterns. In other words, the clue to social and group psychology is the psychology of the individual. Those who hold the view that morality needs to be inculcated teach small children accordingly, and they forgo the pleasure of watching morality develop naturally in their children, who are thriving in a good setting that is provided in a personal and individual way.

I shall not need to examine variations in constitution. We have indeed no clear evidence that any individual who is not mentally defective is constitutionally incapable of developing a moral sense. On the other hand, we do find all degrees of success and failure in the development of a moral sense. I shall attempt to explain these variations. Undoubtedly there are children and adults with a defective guilt-sense, and such defect is not specifically linked with intellectual capacity or incapacity.

[1] Lecture given in a series as part of the celebrations of the centenary of Freud's birth: at Friends' House, April 1956, and first published in *Psycho-Analysis and Contemporary Thought*, ed. J. D. Sutherland. (London: Hogarth, 1958.)

It will simplify my task if I divide my examination of the problem into three main parts:

(1) The sense of guilt in those individuals who have developed and established a capacity for guilt-feeling.
(2) The sense of guilt at the point of its origin in individual emotional development.
(3) The sense of guilt as a feature conspicuous by its absence in certain individual persons.

At the end I shall refer to the loss and recovery of the capacity for guilt-sense.

1. *A Capacity for Sense of Guilt Assumed*

How does the concept of guilt appear in psycho-analytic theory? I think I am right in saying that the early work of Freud in this field had to do with the vicissitudes of guilt-sense in those individuals in whom a capacity for guilt-sense could be taken for granted. I will therefore say something about Freud's view of the meaning of guilt for the unconscious in health, and the psychopathology of guilt-sense.

The work of Freud shows how it is that true guilt resides in the intention, in unconscious intention. Actual crime is not the cause of guilt-feeling; rather is it the *result* of guilt—guilt that belongs to criminal intention. Only legal guilt refers to a crime; moral guilt refers to inner reality. Freud was able to make sense of this paradox. In his early theoretical formulations he was concerned with the id, by which he referred to the instinctual drives, and the ego, by which he referred to that part of the whole self that is related to the environment. The ego modifies the environment in order to bring about id-satisfactions, and it curbs id-impulses in order that what the environment can offer can be used to best advantage, again for id-satisfaction. Later (1923) Freud used the term superego to name that which is accepted by the ego for use in id-control.

Freud is here dealing with human nature in terms of *economics*, and deliberately simplifying the problem for the purpose of founding a theoretical formulation. There is an implied determinism in all this work, an assumption that human nature can be examined objectively and can have applied to it the laws that are known to apply in physics. In ego-id terms the sense of guilt is very little more than *anxiety with a special quality*, anxiety felt because of the conflict between love and hate. Guilt-sense implies tolerance of ambivalence. It is not difficult to accept the close

relationship between guilt and the personal conflict that arises out of coincident loving and hating, but Freud was able to trace the conflict to its roots and to show that the feelings are those associated with the instinctual life. As is now well known, Freud found in analysis of adults (neurotic rather than psychotic) that he regularly came back to the early childhood of the patient, to intolerable anxiety, and to the clash of love and hate. In the simplest possible terms of the Oedipus complex, a boy in *health* achieved a relationship with his mother in which instinct was involved and in which the dream contained an in-love relationship with her. This led to the dream of the death of the father, which in turn led to the fear of the father and the fear that the father would destroy the child's instinctual potential. This is referred to as the castration-complex. At the same time there was the boy's love of the father and his respect for him. The boy's conflict between that side of his nature which made him hate and want to harm his father, and the other side by which he loved him, involved the boy in a sense of guilt. Guilt implied that the boy could tolerate and hold the conflict, which is in fact an inherent conflict, one that belongs to healthy life.

This is all quite simple, except that only through Freud has it been recognized that in health the climax of anxiety and guilt has a date; that is to say, has a first vitally important setting—the small child with biologically-determined instincts living in the family and experiencing the first triangular relationship. (This statement is purposely simplified, and I shall not make any reference here to the Oedipus complex in terms of sibling-relationships, nor any statement of the equivalent to the Oedipus complex in a child brought up away from the parents or in an institution.

In the early psycho-analytic statement there is but little reference to the destructive aims in the love impulse, or to the aggressive drives that only in health become fully fused with the erotic. All this needed eventually to be brought into the theory of the origin of guilt, and I shall examine such developments later. In the first statement guilt arises out of the clash of love and hate, a clash which is inevitable if loving is to include the instinctual element that belongs to it. The prototype has reality at the toddler age.

All psycho-analysts are familiar in their work with the replacement of symptoms by the more normal development, a sense of guilt, and an increased consciousness and acceptance of the content of the fantasy which makes the sense of guilt logical. How illogical the sense of guilt can seem! In Burton's *Anatomy of*

Melancholy there is a good collection of cases illustrating the absurdities of guilt-feeling. In long and deep analysis patients feel guilt about anything and everything, and even about early environmental adverse factors that we can easily discern as chance phenomena. Here is a simple illustration:

A boy of eight became increasingly anxious, and eventually ran away from school. He was found to be suffering from an unbearable sense of guilt because of the death of a sibling that took place some years *prior to his own birth.* He had recently heard about this, and the parents had no idea that he was disturbed by the news. In this case it was not necessary for the boy to have a long analysis. In a few therapeutic interviews he discovered that the crippling sense of guilt which he felt about this death was a displacement from the Oedipus complex. He was a fairly normal boy, and with this amount of help he was able to return to school, and his other symptoms cleared up.

The Superego

The introduction of the concept of the superego (1923) was a big step forward in the inevitably slow evolution of psychoanalytical metapsychology. Freud had done the pioneer work himself, bearing the brunt when the world was disturbed by his drawing attention to the instinctual life of children. Gradually other workers gained experience through the use of the technique, and Freud had many colleagues by the time he used the term superego. With his new term, Freud was indicating that the ego, in coping with the id, employed certain forces which were worthy of a name. The child gradually acquired controlling forces. In the over-simplification of the Oedipus complex, the boy introjected the respected and feared father, and therefore carried about with him controlling forces based on what the child perceived and felt about this father. This introjected father-figure was highly subjective, and coloured by the child's experiences with father-figures other than the actual father and by the cultural pattern of the family. (The word introjection simply meant a mental and emotional acceptance, and this term avoids the more functional implications of the word incorporation.) A sense of guilt therefore implies that the ego is coming to terms with the superego. Anxiety has matured into guilt.

Here in the concept of the superego can be seen the proposition that the genesis of guilt is a matter of inner reality, or that guilt resides in the intention. Here also lies the deepest reason for guilt-feeling related to masturbation and the autoerotic activities generally. Masturbation in itself is no crime, yet

in the total fantasy of masturbation is gathered together all the conscious and unconscious intention.

From this very much simplified statement of the psychology of the boy, psycho-analysis could begin to study and examine the development of the superego in both boys and girls, and also the differences that undoubtedly exist in the male and female in regard to superego formation, in the pattern of conscience, and in the development of a capacity for guilt-feeling. Out of the concept of the superego a great deal has developed. The idea of the introjection of the father-figure has turned out to be too simple. There is an early history of the superego in each individual: the introject may become human and father-like, but in earlier stages the superego introjects, used for control of id-impulses and id-products, are subhuman, and indeed are primitive to any degree. Thus we find ourselves studying guilt-sense in each individual infant and child as it develops from crude fear to something akin to a relationship to a revered human being, one who can understand and forgive. (It has been pointed out that there is a parallel between the maturing of the superego in the individual child and the development of monotheism as depicted in early Jewish history.)

All the time while conceptualizing the processes which underlie the sense of guilt we are keeping in mind the fact that the sense of guilt, even when unconscious and even when apparently irrational, implies a certain degree of emotional growth, ego health, and hope.

The Psycho-pathology of Guilt-sense

It is common to find people who are burdened by a sense of guilt and indeed hampered by it. They carry it round like the load on the back of Christian in *Pilgrim's Progress*. We know that these people have a potentiality for constructive effort. Sometimes when they find a suitable opportunity for constructive work the sense of guilt no longer hampers them and they do exceptionally well; but a failure of opportunity may lead to a return of guilt-feeling, intolerable and inexplicable. We are dealing here with abnormalities of the superego. In a successful analysis of individuals who are oppressed by a sense of guilt, we find a gradual lessening of this burden. This lessening of the burden of guilt-feeling follows the lessening of repression, or the approach of the patient towards the Oedipus complex and an acceptance of responsibility for all the hate and love that this involves. This does not mean that the patients lose the capacity for a sense of guilt (except in so far as in some cases there may

have been a false superego development based in an abnormal way on the intrusion of a very powerful authoritarian influence derived from the environment of early years).

We can study these excesses of guilt-feeling in individuals who pass for normal, and who indeed may be among the most valuable members of society. It is easier, however, to think in terms of illness, and the two illnesses that must be considered are melancholia and obsessional neurosis. There is an inter-relationship between these two illnesses, and we find patients who alternate between one and the other.

In obsessional neurosis, the patient is always trying to put something right; but it is quite clear to all observers, and perhaps to the patient, that there will be no success. We know that Lady Macbeth cannot undo the past and get away from her evil intentions by washing her hands. In obsessional neurosis we sometimes get a ritual which is like a caricature of a religion, as if the God of the religion were dead or temporarily unavailable. Obsessive thinking may be a feature whereby every attempt is made to annul one idea by another, but nothing succeeds. Behind the whole process is a confusion, and no amount of tidying that the patient can do alters this confusion, because it is maintained; it is unconsciously maintained in order to hide something very simple; namely, the fact that, in some specific setting of which the patient is unaware, hate is more powerful than love.

I will cite the case of a girl who could not go to the seaside because she saw in the waves someone crying out for help. Intolerable guilt made her go to absurd lengths in arranging for vigilance and rescue. The absurdity of the symptom could be shown by the fact that she could not tolerate even a picture postcard of the sea coast. If she saw one by chance in a shop-window she would have to find out who took the photograph, because she would see someone drowning, and she would have to organize relief, in spite of the fact that she knew perfectly well that the photograph was taken months and even years previously. This very ill girl was able eventually to come through to a fairly normal life, much less hampered by irrational guilt-feeling; but the treatment was necessarily of long duration.

Melancholia is an organized form of the depressed mood to which almost all people are liable. A melancholic patient may be paralysed by a sense of guilt, and may sit for years accusing himself or herself of causing the world war. No argument has any effect whatever. When it is possible to carry out an analysis of such a case, it is found that this gathering into the self of guilt for all the people in the world gives way in the treatment to the

patient's fear that hate will be greater than love. The illness is an attempt to do the impossible. The patient absurdly claims responsibility for general disaster, but in so doing avoids reaching his or her personal destructiveness.

A little girl of five reacted with a deep depression to the death of her father which took place in unusual circumstances. The father had bought a car at a time when the little girl was going through a phase in which she was hating her father as well as loving him. She was, in fact, having dreams of his death, and when he proposed a car ride she implored him not to go. He insisted on going, as would be natural since children are liable to these nightmares. The family went for a ride, and it happened that they had an accident; the car was turned over and the little girl was the only one who was uninjured. She went up to her father who was lying in the road and kicked him to wake him up. But he was dead. I was able to watch this child through her serious depressive illness in which she had almost total apathy. For hours she stood in my room and nothing happened. One day she kicked the wall very gently with the same foot that she had used to kick her dead father to wake him up. I was able to put into words her wish to wake her father whom she loved, though in kicking him she was also expressing anger. From that moment of her kicking the wall she gradually came back into life, and after a year or so was able to return to school and to lead a normal life.

It was possible to have an intuitive understanding of unexplained guilt and of obsessional and melancholic illnesses apart from psycho-analysis. It is probably true, however, to say that it is only Freud's instrument of psycho-analysis and its derivatives that have made it possible for us to help the individual who is burdened by guilt-feeling to find the true origin of the sense of guilt in his or her own nature. The sense of guilt, seen this way, is a special form of anxiety associated with ambivalence, or co-existing love and hate. But ambivalence and the toleration of it by the individual implies a considerable degree of growth and health.

2. *Guilt at its Point of Origin*

I now come to a study of the point of origin of this capacity for guilt-sense, a point which exists in each individual. Melanie Klein (1935) drew the attention of psycho-analysts to a very important stage in emotional development to which she gave the name, 'the depressive position'. Her work on the origin of the capacity for guilt-sense in the human individual is an important result of the continued application of Freud's method. It is not

possible to do justice to the complexities of the concept of the depressive position in a lecture of this length, but I will attempt a very brief statement.

It should be noted that whereas the earlier work of psycho-analysis dwelt on the conflict between love and hate, especially in the three-body or triangular situation, Melanie Klein more especially has developed the idea of conflict in the simple two-body relationship of the infant to the mother, conflict arising out of the destructive ideas that accompany the love impulse. Naturally, the date of the original version of this stage in an individual's development is earlier than the date of the Oedipus complex.

The accent changes. In previous work the accent was on the satisfaction that the infant obtained from instinctual experience. Now the accent shifts on to the aim, as it gradually appears. When Mrs Klein says that the infant aims at breaking ruthlessly through into the mother to take out of her everything that is felt there to be good, she is not of course denying the simple fact that instinctual experiences yield satisfaction. Nor was the aim altogether neglected in the earlier psycho-analytic formulations. Klein has developed the idea, however, that the primitive love impulse has an aggressive aim; being ruthless, it carries with it a variable quantity of destructive ideas unaffected by concern. These ideas may be very restricted at the beginning, but the infant we are watching and caring for need not be many months old before we can be fairly certain that we can perceive also the beginnings of concern—concern as to the results of the instinctual moments that belong to the developing love of the mother. If the mother behaves in that highly adaptive way which may come naturally to her, she is able to give plenty of time for the infant to come to terms with the fact that the object of the ruthless attack is the mother, the same person who is responsible for the total infant-care situation. It can be seen that the infant has two concerns; one as to the effect of the attack on the mother, and the other as to the results in the infant's own self according to whether there was a predominance of satisfaction or of frustration and anger. (I have used the expression primitive love impulse, but in Klein's writings the reference is to the aggression that is associated with the frustrations that inevitably disturb instinctual satisfactions as the child begins to be affected by the demands of reality.)

A great deal is being assumed here. For instance, we assume that the child is becoming a unit, and is becoming able to perceive the mother as a person. We also assume an ability to bring together the aggressive and erotic instinctual components into a

sadistic experience, as well as an ability to find an object at the height of instinctual excitement. All of these developments may go wrong in their earlier stages, those stages which belong to the very beginning of life after birth and which depend on the mother and her natural handling of her infant. When we speak of the origins of guilt-sense, we assume healthy development at earlier stages. At what is called the depressive position the infant is not so much dependent on the mother's simple ability to hold a baby, which was her characteristic at the earlier stages, as on her ability to hold the infant-care situation over a period of time during which the infant may go through complex experiences. If time is given—a few hours maybe—the infant is able to work through the results of an instinctual experience. The mother, being still there, is able to be ready to receive and to understand if the infant has the natural impulse to give or to repair. At this stage in particular the infant is not able to deal with a succession of minders or prolonged absence of the mother. The infant's need for opportunity to make reparation and restitution, if oral sadism is to be accepted by the immature ego, is the second contribution of Klein to this field.

Bowlby (1958) has been particularly interested in making the public aware of the need of every small child for a certain degree of reliability and continuity in external relationships. In the seventeenth century Richard Burton listed among the causes of melancholy: 'non-necessary, outward, adventitious, or accidental causes: as from the Nurse'. He was thinking partly in terms of the passage of noxious matters from the nurse via the milk, but not entirely so. For instance, he quotes from Aristotle who '. . . would not have a child put to nurse at all, but every mother to bring up her own, of what condition soever she be: . . . the mother will be more careful, loving and attendant, than any servile woman, or such hired creatures; this all the world acknowledgeth. . . .'

The observation of the origin of concern is better made in the analysis of a child or an adult than by direct observation of infants. In formulating these theories we do, of course, need to allow for distortions and sophistications that come from the reporting back that is inherent in the analytic situation. We are able, however, to get a view in our work of this most important development in human individuals, the origin of the capacity for a sense of guilt. Gradually as the infant finds out that the mother survives and accepts the restitutive gesture, so the infant becomes able to accept responsibility for the total fantasy of the full instinctual impulse that was previously ruthless. Ruthlessness

gives way to ruth, unconcern to concern. (These terms refer to early development.)

In analysis one could say: 'couldn't care less' gives way to guilt-feeling. There is a gradual building up towards this point. No more fascinating experience awaits the analyst than the observation of the gradual build-up of the individual's capacity to tolerate the aggressive elements in the primitive love impulse. As I have said, this involves a gradual recognition of the difference between fact and fantasy, and of the mother's capacity to survive the instinctual moment, and so to be there to receive and understand the true reparative gesture.

As will be readily understood, this important phase of development is composed of innumerable repetitions spread over a period of time. There is a benign circle of (i) instinctual experience, (ii) acceptance of responsibility which is called guilt, (iii) a working through, and (iv) a true restitutive gesture. This can be reversed into a malign circle if something goes wrong at any point, in which case we see an undoing of the capacity for a sense of guilt and its replacement by inhibition of instinct or some other primitive form of defence, such as the splitting of objects into good and bad, etc. The question will certainly be asked: at what age in the normal child's development can the capacity for guilt-sense be said to become established? I suggest that we are talking about the first year of the infant's life, and in fact about the whole period in which the infant is having a clearly human two-body relationship with the mother. There is no need to claim that these things happen very early, although possibly they do. By the age of six months an infant can be seen to have a highly complex psychology, and it is possible that the *beginnings* of the depressive position are to be found by this age. There are immense difficulties in fixing the date of the origin of the guilt-feelings in the normal infant, and although it is a matter of great interest to seek an answer, the actual work of analysis is not affected by this issue.

There is a great deal in Melanie Klein's further work that I shall not be able to describe in this lecture, although it is relevant. In particular she has enriched our understanding of the complex relationship between fantasy and Freud's concept of inner reality, a concept that was clearly derived from philosophy. Klein has studied the interplay of what is felt by the infant to be benign or malevolent in terms of forces or objects within the self. This third contribution that she has made in this particular field reaches towards the problem of the eternal struggle in man's inner nature. Through the study of the growth of the infant's

and the child's inner reality, we get a glimpse of the reason why there exists a relationship between the deepest conflicts that reveal themselves in religion and in art forms and the depressed mood or melancholic illness. At the centre is doubt, doubt as to the outcome of the struggle between the forces of good and evil, or in psychiatric terms, between the benign and persecutory elements within and without the personality. At the depressive position in the emotional development of an infant or a patient, we see the building up of the good and bad according to whether the instinctual experiences are satisfactory or frustrative. The good becomes protected from the bad, and a highly complex personal pattern is established as a system of defence against chaos within and without.

From my personal point of view, the work of Klein has enabled psycho-analytic theory to begin to include the idea of an individual's *value*, whereas in early psycho-analysis the statement was in terms of *health* and neurotic *ill-health*. Value is intimately bound up with the capacity for guilt-feeling.

3. *Sense of Guilt Conspicuous by its Absence*

I have now reached the third part of my lecture, in which I shall first briefly refer to the lack of a moral sense. Undoubtedly, in a proportion of people there is a lack of capacity for guilt-sense. The extreme of this incapacity for concern must be rare. But it is not rare to find individuals who have made a healthy development only in part, and who in part are unable to achieve concern or guilt-feeling, or even remorse. It is tempting here to fall back for an explanation on to the constitutional factor, which of course can never be ignored. However, psycho-analysis offers another explanation. This is that those who lack moral sense have lacked at the early stages of their development the emotional and physical setting which would have enabled a capacity for guilt-sense to have developed.

It should be understood that I am not denying that each infant carries a tendency towards the development of guilt. Given certain conditions of physical health and care, walking and talking appear because the time has come for these developments. In the case of the development of a capacity for guilt-feeling, the necessary environmental conditions are, however, of a much more complex order, comprising indeed all that is natural and reliable in infant and child care. In the earliest stages of the emotional development of the individual, we must not look for a guilt-sense. The ego is not sufficiently strong and organized to accept

responsibility for id-impulses, and dependence is near absolute. If there is satisfactory development in the earliest stages, there comes about an ego integration which makes possible the beginning of a capacity for concern. Gradually, in favourable circumstances, a capacity for guilt-sense builds up in the individual in relation to the mother, and this is intimately related to the opportunity for reparation. When the capacity for concern is established, the individual begins to be in a position to experience the Oedipus complex, and to tolerate the ambivalence that is inherent at the later stage in which the child, if mature, is involved in triangular relationships as between whole human beings.

In this context I can do no more than acknowledge the fact that in some persons, or in a part of some persons, there is a stunting of emotional development in the earliest phases, and consequently an absence of moral sense. Where there is lack of personal moral sense the implanted moral code is necessary, but the resultant socialization is unstable.

The Creative Artist

It is interesting to note that the creative artist is able to reach to a kind of socialization which obviates the need for guilt-feeling and the associated reparative and restitutive activity that forms the basis for ordinary constructive work. The creative artist or thinker may, in fact, fail to understand, or even may despise, the feelings of concern that motivate a less creative person; and of artists it may be said that some have no capacity for guilt and yet achieve a socialization through their exceptional talent. Ordinary guilt-ridden people find this bewildering; yet they have a sneaking regard for ruthlessness that does in fact, in such circumstances, achieve more than guilt-driven labour.

Loss and Recovery of Guilt-sense

In our management of antisocial children and adults we can watch the loss or recovery of the capacity for guilt-sense, and often we are in a position to assess the variations in environmental reliability which produce these effects. It is at this point of loss and recovery of moral sense that we can study delinquency and recidivism. Freud wrote in 1915 (referring to adolescent and pre-adolescent acts, such as thefts, frauds, and arson, in people who have eventually become socially adjusted): 'Analytic work . . . brought the surprising discovery that such deeds were done principally *because* [my italics] they were forbidden, and because their execution was accompanied by mental relief for their doer. He was suffering from an oppressive feeling of guilt, of which he did

not know the origin, and after he had committed a misdeed this oppression was mitigated. His sense of guilt was at least attached to something' (Freud, 1915, p. 332). Although Freud was referring to late stages in development, what he wrote applies also to children.

From our analytic work we can roughly divide antisocial behaviour into two kinds. The first is common and closely allied to the ordinary naughtiness of healthy children. In terms of behaviour the complaint is of stealing, lying, destructiveness, and bed-wetting. Repeatedly we find that these acts are done in an unconscious attempt to make sense of guilt-feeling. The child or adult cannot reach the source of a sense of guilt that is intolerable, and the fact that the guilt-feeling cannot be explained makes for a feeling of madness. The antisocial person gets relief by devising a limited crime which is only in a disguised way in the nature of the crime in the repressed fantasy that belongs to the original Oedipus complex. This is the closest that the antisocial person can get to the ambivalence belonging to the Oedipus complex. At first the substitute crime or delinquency is unsatisfactory to the delinquent, but when compulsively repeated it acquires the characteristics of secondary gain and thus becomes acceptable to the self. Our treatment is more likely to be effectual when we can apply it before secondary gain has become important. In this, the more common variety of antisocial behaviour, it is not so much the guilt that is repressed as the fantasy that explains the guilt.

By contrast, in the more serious and more rare antisocial episodes it is precisely the capacity for guilt-feeling that is lost. Here we find the most ugly crimes. We see the criminal engaged in a desperate attempt to feel guilty. It is unlikely that he ever succeeds. In order to develop a capacity for guilt-sense, such a person must find an environment of a specialized kind; in fact, we must supply for him an environment that corresponds to that which is normally needed by the immature infant. It is notoriously difficult to provide such an environment, which must be able to take up all the strains resulting from ruthlessness and impulsiveness. We find ourselves dealing with an infant, but one who has the strength and cunning of the older child or adult.

In the management of the more common type of case in which there is antisocial behaviour we are frequently able to produce a cure by rearrangement of the environment, basing what we do on the understanding that Freud has given us.

I shall give an example, that of a boy who was stealing at school. The headmaster, instead of punishing him, recognized that he was ill

and recommended psychiatric consultation. This boy at the age of nine was dealing with a deprivation belonging to an earlier age, and what he needed was a period at home. His family had become reunited and this had given him a new hope. I found that the boy had been under a compulsion to steal, hearing a voice that ordered him about, the voice of a wizard. At home he became ill, infantile, dependent, enuretic, apathetic. His parents met his needs and allowed him to be ill. In the end they were rewarded by his making a spontaneous recovery. After a year he was able to return to boarding-school, and the recovery has proved to be a lasting one.

It would have been easy to have diverted this boy from the path that led to his recovery. He was of course unaware of the intolerable loneliness and emptiness that lay at the back of his illness, and which made him adopt the wizard in place of a more natural superego organization; this loneliness belonged to a time of separation from his family when he was five. If he had been thrashed or if the headmaster had told him that he ought to feel wicked, he would have hardened up and organized a fuller identification with the wizard; he would then have become domineering and defiant and eventually an antisocial person. This is a common type of case in child psychiatry, and I choose it simply because it is a published case and reference can be made to it for further details (Winnicott, 1953).

We cannot hope to cure many of those who have become delinquent, but we can hope to understand how to prevent the development of the antisocial tendency. We can at least avoid interrupting the developing relationship between mother and baby. Also, applying these principles to the ordinary upbringing of children, we can see the need for some strictness in management where the child's own guilt-sense is still primitive and crude; by limited prohibitions we give opportunity for that limited naughtiness which we call healthy, and which contains much of the child's spontaneity.

More than anyone else it was Freud who paved the way for the understanding of antisocial behaviour and of crime as a *sequel* to an unconscious criminal intention, and a symptom of a failure in child-care. I suggest that in putting forward these ideas and showing how we can test them and use them Freud has made a contribution to social psychology which can have far-reaching results.

2

THE CAPACITY TO BE ALONE[1]

(1958)

I wish to make an examination of the capacity of the individual to be alone, acting on the assumption that this capacity is one of the most important signs of maturity in emotional development.

In almost all our psycho-analytic treatments there come times when the ability to be alone is important to the patient. Clinically this may be represented by a silent phase or a silent session, and this silence, far from being evidence of resistance, turns out to be an achievement on the part of the patient. Perhaps it is here that the patient has been able to be alone for the first time. It is to this aspect of the transference in which the patient is alone in the analytic session that I wish to draw attention.

It is probably true to say that in psycho-analytical literature more has been written on the *fear* of being alone or the *wish* to be alone than on the *ability* to be alone; also a considerable amount of work has been done on the withdrawn state, a defensive organization implying an expectation of persecution. It would seem to me that a discussion on the *positive* aspects of the capacity to be alone is overdue. In the literature there may be specific attempts to state the capacity to be alone, but I am not aware of these. I wish to make reference to Freud's (1914) concept of the *anaclitic relationship* (cf. Winnicott, 1956a).

Three- and Two-Body Relationships

Rickman introduced us to the idea of thinking in terms of three-body and two-body relationships. We often refer to the Oedipus complex as a stage in which three-body relationships dominate the field of experience. Any attempt to describe the Oedipus complex in terms of two people must fail. Nevertheless two-body relationships do exist, and these belong to relatively earlier stages in the history of the individual. The original two-body relationship is that of the infant and the mother or mother-substitute, before any property of the mother has been sorted out

[1] Based on a paper read at an Extra Scientific Meeting of the British Psycho-Analytical Society, 24 July 1957, and first published in the *Int. J. Psycho-Anal.*, **39**, pp. 416–20.

and moulded into the idea of a father. The Klein concept of the depressive position can be described in terms of two-body relationships, and it is perhaps true to say that a two-body relationship is an essential feature of the concept.

After thinking in terms of three- and two-body relationships, how natural that one should go a stage further back and speak of a one-body relationship! At first it would seem that narcissism would be the one-body relationship, either an early form of secondary narcissism or primary narcissism itself. I am suggesting that this jump from two-body relationships to a one-body relationship cannot, in fact, be made without violation of a great deal that we know through our analytic work and through direct observation of mothers and infants.

Actually Being Alone

It will be appreciated that actually to be alone is not what I am discussing. A person may be in solitary confinement, and yet not be able to be alone. How greatly he must suffer is beyond imagination. However, many people do become able to enjoy solitude before they are out of childhood, and they may even value solitude as a most precious possession.

The capacity to be alone is either a highly sophisticated phenomenon, one that may arrive in a person's development *after* the establishment of three-body relationships, or else it is a phenomenon of early life which deserves special study because it is the foundation on which sophisticated aloneness is built.

Paradox

The main point of this contribution can now be stated. Although many types of experience go to the establishment of the capacity to be alone, there is one that is basic, and without a sufficiency of it the capacity to be alone does not come about; *this experience is that of being alone, as an infant and small child, in the presence of mother.* Thus the basis of the capacity to be alone is a paradox; it is the experience of being alone while someone else is present.

Here is implied a rather special type of relationship, that between the infant or small child who is alone, and the mother or mother-substitute who is in fact reliably present even if represented for the moment by a cot or a pram or the general atmosphere of the immediate environment. I would like to suggest a name for this special type of relationship.

Personally I like to use the term *ego-relatedness*, which is convenient in that it contrasts rather clearly with the word *id-relationship*, which is a recurring complication in what might be

called ego life. Ego-relatedness refers to the relationship between two people, one of whom at any rate is alone; perhaps both are alone, yet the presence of each is important to the other. I consider that if one compares the meaning of the word 'like' with that of the word 'love', one can see that liking is a matter of ego-relatedness, whereas loving is more a matter of id-relationships, either crude or in sublimated form.

Before developing these two ideas in my own way I wish to remind you how it would be possible to refer to the capacity to be alone in well-worn psycho-analytic phraseology.

After Intercourse

It is perhaps fair to say that after satisfactory intercourse each partner is alone and is contented to be alone. Being able to enjoy being alone along with another person who is also alone is in itself an experience of health. Lack of id-tension may produce anxiety, but time-integration of the personality enables the individual to wait for the natural return of id-tension, and to enjoy sharing solitude, that is to say, solitude that is relatively free from the property that we call 'withdrawal'.

Primal Scene

It could be said that an individual's capacity to be alone depends on his ability to deal with the feelings aroused by the primal scene. In the primal scene an excited relationship between the parents is perceived or imagined, and this is accepted by the child who is healthy and who is able to master the hate and to gather it into the service of masturbation. In masturbation the whole responsibility for the conscious and unconscious fantasy is accepted by the individual child, who is the third person in a three-body or triangular relationship. To be able to be alone in these circumstances implies a maturity of erotic development, a genital potency or the corresponding female acceptance; it implies fusion of the aggressive and erotic impulses and ideas, and it implies a tolerance of ambivalence; along with all this there would naturally be a capacity on the part of the individual to identify with each of the parents.

A statement in these or any terms could become almost infinitely complex, because the capacity to be alone is so nearly synonymous with emotional maturity.

Good Internal Object

I will now attempt to use another language, one that derives from the work of Melanie Klein. The capacity to be alone

depends on the existence of a good object in the psychic reality of the individual. The good internal breast or penis or the good internal relationships are well enough set up and defended for the individual (at any rate for the time being) to feel confident about the present and the future. The relationship of the individual to his or her internal objects, along with confidence in regard to internal relationships, provides of itself a sufficiency of living, so that temporarily he or she is able to rest contented even in the absence of external objects and stimuli. Maturity and the capacity to be alone implies that the individual has had the chance through good-enough mothering to build up a belief in a benign environment. This belief is built up through a repetition of satisfactory instinctual gratifications.

In this language one finds oneself referring to an earlier stage in the individual's development than that at which the classical Oedipus complex holds sway. Nevertheless a considerable degree of ego maturity is being assumed. The integration of the individual into a unit is assumed, otherwise there would be no sense in making reference to the inside and the outside, or in giving special significance to the fantasy of the inside. In negative terms: there must be a relative freedom from persecutory anxiety. In positive terms: the good internal objects are in the individual's personal inner world, and are available for projection at a suitable moment.

To be Alone in an Immature State

The question which will be asked at this point is this: Can a child or an infant be alone at a very early stage when ego immaturity makes it impossible for a description of being alone to be given in the phraseology that has just been employed? It is the main part of my thesis that we do need to be able to speak of an unsophisticated form of being alone, and that even if we agree that the capacity to be truly alone is a sophistication, the ability to be truly alone has as its basis the early experience of being alone in the presence of someone. Being alone in the presence of someone can take place at a very early stage, when the *ego immaturity is naturally balanced by ego-support* from the mother. In the course of time the individual introjects the ego-supportive mother and in this way becomes able to be alone without frequent reference to the mother or mother symbol.

'*I am Alone*'

I would like to take up this subject in a different way by studying the words 'I am alone'.

First there is the word 'I', implying much emotional growth. The individual is established as a unit. Integration is a fact. The external world is repudiated and an internal world has become possible. This is simply a topographical statement of the personality as a thing, as an organization of ego-nuclei. At this point no reference is being made to living.

Next come the words 'I am', representing a stage in individual growth. By these words the individual not only has shape but also life. In the beginnings of 'I am' the individual is (so to speak) raw, is undefended, vulnerable, potentially paranoid. The individual can only achieve the 'I am' stage because there exists an environment which is protective; the protective environment is in fact the mother preoccupied with her own infant and orientated to the infant's ego requirements through her identification with her own infant. There is no need to postulate an awareness of the mother on the part of the infant at this stage of 'I am'.

Next I come to the words 'I am alone'. According to the theory that I am putting forward this further stage does indeed involve an appreciation on the part of the infant of the mother's continued existence. By this I do not necessarily mean an awareness with the conscious mind. I consider, however, that 'I am alone' is a development from 'I am', dependent on the infant's awareness of the continued existence of a reliable mother whose reliability makes it possible for the infant to be alone and to enjoy being alone, for a limited period.

In this way I am trying to justify the paradox that the capacity to be alone is based on the experience of being alone in the presence of someone, and that without a sufficiency of this experience the capacity to be alone cannot develop.

'*Ego-relatedness*'

Now, if I am right in the matter of this paradox, it is interesting to examine the nature of the relationship of the infant to the mother, that which for the purposes of this paper I have called ego-relatedness. It will be seen that I attach a great importance to this relationship, as I consider that it is the stuff out of which friendship is made. It may turn out to be the *matrix of transference.*

There is a further reason why I put a special importance on this matter of ego-relatedness, but in order to make my meaning clear I must digress for a moment.

I think it will be generally agreed that id-impulse is significant only if it is contained in ego living. An id-impulse either disrupts a weak ego or else strengthens a strong one. It is possible to say

that *id-relationships strengthen the ego when they occur in a framework of ego-relatedness*. If this be accepted, then an understanding of the importance of the capacity to be alone follows. It is only when alone (that is to say, in the presence of someone) that the infant can discover his own personal life. The pathological alternative is a false life built on reactions to external stimuli. When alone in the sense that I am using the term, and only when alone, the infant is able to do the equivalent of what in an adult would be called relaxing. The infant is able to become unintegrated, to flounder, to be in a state in which there is no orientation, to be able to exist for a time without being either a reactor to an external impingement or an active person with a direction of interest or movement. The stage is set for an id experience. In the course of time there arrives a sensation or an impulse. In this setting the sensation or impulse will feel real and be truly a personal experience.

It will now be seen why it is important that there is someone available, someone present, although present without making demands; the impulse having arrived, the id experience can be fruitful, and the object can be a part or the whole of the attendant person, namely the mother. It is only under these conditions that the infant can have an experience which feels real. A large number of such experiences form the basis for a life that has reality in it instead of futility. The individual who has developed the capacity to be alone is constantly able to rediscover the personal impulse, and the personal impulse is not wasted because the state of being alone is something which (though paradoxically) always implies that someone else is there.

In the course of time the individual becomes able to forgo the *actual* presence of a mother or mother-figure. This has been referred to in such terms as the establishment of an 'internal environment'. It is more primitive than the phenomenon which deserves the term 'introjected mother'.

Climax in Ego-relatedness

I would now like to go a little further in speculating in regard to the ego-relatedness and the possibilities of experience within this relationship, and to consider the concept of an *ego orgasm*. I am of course aware that if there is such a thing as an ego orgasm, those who are inhibited in instinctual experience will tend to specialize in such orgasms, so that there would be a pathology of the tendency to ego orgasm. At the moment I wish to leave out consideration of the pathological, not forgetting identification of the whole body with a part-object (phallus), and

to ask only whether there can be a value in thinking of *ecstasy* as an ego orgasm. In the normal person a highly satisfactory experience such as may be obtained at a concert or at the theatre or in a friendship may deserve a term such as ego orgasm, which draws attention to the climax and the importance of the climax. It may be thought unwise that the word orgasm should be used in this context; I think that even so there is room for a discussion of the climax that may occur in satisfactory ego-relatedness. One may ask: when a child is playing, is the whole of the game a sublimation of id-impulse? Could there not be some value in thinking that there is a difference of *quality* as well as of *quantity of id* when one compares the game that is satisfactory with the instinct that crudely underlies the game? The concept of sublimation is fully accepted and has great value, but it is a pity to omit reference to the vast difference that exists between the happy playing of children and the play of children who get compulsively excited and who can be seen to be very near to an instinctual experience. It is true that even in the happy playing of the child everything can be *interpreted* in terms of id-impulse; this is possible because we talk in terms of symbols, and we are undoubtedly on safe ground in our use of symbolism and our understanding of all play in terms of id-relationships. Nevertheless, we leave out something vital if we do not remember that the play of a child is not happy when complicated by bodily excitements with their physical climaxes.

The so-called normal child is able to play, to get excited while playing, and to feel *satisfied with the game*, without feeling threatened by a physical orgasm of local excitement. By contrast, a deprived child with antisocial tendency, or any child with marked manic-defence restlessness, is unable to enjoy play because the body becomes physically involved. A physical climax is needed, and most parents know the moment when nothing brings an exciting game to an end except a smack—which provides a false climax, but a very useful one. In my opinion, if we compare the happy play of a child or the experience of an adult at a concert with a sexual experience, the difference is so great that we should do no harm in allowing a different term for the description of the two experiences. Whatever the unconscious symbolism, the quantity of actual physical excitement is minimal in the one type of experience and maximal in the other. We may pay tribute to the importance of ego-relatedness *per se* without giving up the ideas that underlie the concept of sublimation.

Summary

The capacity to be alone is a highly sophisticated phenomenon and has many contributory factors. It is closely related to emotional maturity.

The basis of the capacity to be alone is the experience of being alone in the presence of someone. In this way an infant with weak ego organization may be alone because of reliable ego-support.

The type of relationship that exists between an infant and the ego-supportive mother deserves special study. Although other terms have been used, I suggest that ego-relatedness might be a good term for temporary use.

In a frame of ego-relatedness, id-relationships occur and strengthen rather than disrupt the immature ego.

Gradually, the ego-supportive environment is introjected and built into the individual's personality, so that there comes about a capacity actually to be alone. Even so, theoretically, there is always someone present, someone who is equated ultimately and unconsciously with the mother, the person who, in the early days and weeks, was temporarily identified with her infant, and for the time being was interested in nothing else but the care of her own infant.

3

THE THEORY OF THE PARENT-INFANT RELATIONSHIP[1]

(1960)

The main point of this paper can perhaps best be brought out through a comparison of the study of infancy with the study of the psycho-analytic transference.[2] It cannot be too strongly emphasized that my statement is about infancy, and not primarily about psycho-analysis. The reason why this must be understood reaches to the root of the matter. If this paper does not contribute constructively, then it can only add to the existing confusion about the relative importance of personal and environmental influences in the development of the individual.

In psycho-analysis as we know it there is no trauma that is outside the individual's omnipotence. Everything eventually comes under ego-control, and thus becomes related to secondary processes. The patient is not helped if the analyst says: 'Your mother was not good enough' . . . 'your father really seduced you' . . . 'your aunt dropped you.' Changes come in an analysis when the traumatic factors enter the psycho-analytic material in the patient's own way, and within the patient's omnipotence. The interpretations that are alterative are those that can be made in terms of projection. The same applies to the benign factors, factors that led to satisfaction. Everything is interpreted in terms of the individual's love and ambivalence. The analyst is prepared to wait a long time to be in a position to do exactly this kind of work.

In infancy, however, good and bad things happen to the infant that are quite outside the infant's range. In fact infancy is the period in which the capacity for gathering external factors into the area of the infant's omnipotence is in process of formation. The ego-support of the maternal care enables the infant to live and develop in spite of his being not yet able to control, or to feel responsible for, what is good and bad in the environment.

[1] This paper, together with one by Dr Phyllis Greenacre on the same theme, was the subject of a discussion at the 22nd International Psycho-Analytical Congress at Edinburgh, 1961. It was first published in the *Int. J. Psycho-Anal.*, **42**, pp. 585–95.

[2] I have discussed this from a more detailed clinical angle in *Primitive Emotional Development* (1945).

The events of these earliest stages cannot be thought of as lost through what we know as the mechanisms of repression, and therefore analysts cannot expect to find them appearing as a result of work which lessens the forces of repression. It is possible that Freud was trying to allow for these phenomena when he used the term primary repression, but this is open to argument. What is fairly certain is that the matters under discussion here have had to be taken for granted in much of the psycho-analytic literature.[1]

Returning to psycho-analysis, I have said that the analyst is prepared to wait till the patient becomes able to present the environmental factors in terms that allow of their interpretation as projections. In the well-chosen case this result comes from the patient's capacity for confidence, which is rediscovered in the reliability of the analyst and the professional setting. Sometimes the analyst needs to wait a very long time; and in the case that is *badly* chosen for classical psycho-analysis it is likely that the reliability of the analyst is the most important factor (or more important than the interpretations) because the patient did not experience such reliability in the maternal care of infancy, and if the patient is to make use of such reliability he will need to find it for the first time in the analyst's behaviour. This would seem to be the basis for research into the problem of what a psycho-analyst can do in the treatment of schizophrenia and other psychoses.

In borderline cases the analyst does not always wait in vain; in the course of time the patient becomes able to make use of the psycho-analytic interpretations of the original traumata as projections. It may even happen that he is able to accept what is good in the environment as a projection of the simple and stable going-on-being elements that derive from his own inherited potential.

The paradox is that what is good and bad in the infant's environment is not in fact a projection, but in spite of this it is necessary, if the individual infant is to develop healthily, that everything shall seem to him to be a projection. Here we find omnipotence and the pleasure principle in operation, as they certainly are in earliest infancy; and to this observation we can add that the recognition of a true 'not-me' is a matter of the intellect; it belongs to extreme sophistication and to the maturity of the individual.

In the writings of Freud most of the formulations concerning

[1] I have reported (1954) some aspects of this problem, as met with in the case of a female patient while she was in deep regression.

infancy derive from a study of adults in analysis. There are some childhood observations ('Cotton reel' material (1920)), and there is the analysis of Little Hans (1909). At first sight it would seem that a great deal of psycho-analytic theory is about early childhood and infancy, but in one sense Freud can be said to have neglected infancy as a state. This is brought out by a footnote in *Formulations on the Two Principles of Mental Functioning* (1911, p. 220) in which he shows that he knows he is taking for granted the very things that are under discussion in this paper. In the text he traces the development from the pleasure-principle to the reality-principle, following his usual course of reconstructing the infancy of his adult patients. The note runs as follows:

> It will rightly be objected that an organization which was a slave to the pleasure-principle and neglected the reality of the external world could not maintain itself alive for the shortest time, so that it could not have come into existence at all. The employment of a fiction like this is, however, justified when one considers that the infant—provided one includes with it the care it receives from its mother—does almost realize a psychical system of this kind.

Here Freud paid full tribute to the function of maternal care, and it must be assumed that he left this subject alone only because he was not ready to discuss its implications. The note continues:

> It probably hallucinates the fulfilment of its internal needs; it betrays its unpleasure, when there is an increase of stimulus and an absence of satisfaction, by the motor discharge of screaming and beating about with its arms and legs, and it then experiences the satisfaction it has hallucinated. Later, as an older child, it learns to employ these manifestations of discharge intentionally as methods of expressing its feelings. Since the later care of children is modelled on the care of infants, the dominance of the pleasure-principle can really come to an end only when a child has achieved complete psychical detachment from its parents.

The words: 'provided one includes with it the care it receives from its mother' have great importance in the context of this study. The infant and the maternal care together form a unit.[1] Certainly if one is to study the theory of the parent-infant relationship one must come to a decision about these matters, which concern the real meaning of the word dependence. It is not enough that it is acknowledged that the environment is

[1] I once said: 'There is no such thing as an infant', meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant. (Discussion at a Scientific Meeting of the British Psycho-Analytical Society, *circa* 1940.) Was I influenced, without knowing it, by this footnote of Freud's?

important. If there is to be a discussion of the theory of the parent-infant relationship, then we are divided into two if there are some who do not allow that at the earliest stages the infant and the maternal care belong to each other and cannot be disentangled. These two things, the infant and the maternal care, disentangle and dissociate themselves in health; and health, which means so many things, to some extent means a disentanglement of maternal care from something which we then call the infant or the beginnings of a growing child. This idea is covered by Freud's words at the end of the footnote: 'the dominance of the pleasure-principle can really come to an end only when a child has achieved complete psychical detachment from its parents'. (The middle part of this footnote will be discussed in a later section, where it will be suggested that Freud's words here are inadequate and misleading in certain respects, if taken to refer to the earliest stage.)

The Word 'Infant'

In this paper the word infant will be taken to refer to the very young child. It is necessary to say this because in Freud's writings the word sometimes seems to include the child up to the age of the passing of the Oedipus complex. Actually the word infant implies 'not talking' (*infans*), and it is not un-useful to think of infancy as the phase prior to word presentation and the use of word symbols. The corollary is that it refers to a phase in which the infant depends on maternal care that is based on maternal empathy rather than on understanding of what is or could be verbally expressed.

This is essentially a period of ego development, and integration is the main feature of such development. The id-forces clamour for attention. At first they are external to the infant. In health the id becomes gathered into the service of the ego, and the ego masters the id, so that id-satisfactions become ego-strengtheners. This, however, is an achievement of healthy development and in infancy there are many variants dependent on relative failure of this achievement. In the ill-health of infancy achievements of this kind are minimally reached, or may be won and lost. In infantile psychosis (or schizophrenia) the id remains relatively or totally 'external' to the ego, and id-satisfactions remain physical, and have the effect of threatening the ego structure, that is, until defences of psychotic quality are organized.[1]

[1] I have tried to show the application of this hypothesis to an understanding of psychosis in my paper, 'Psychoses and Child Care' (Winnicott, 1952).

I am here supporting the view that the main reason why in infant development the infant usually becomes able to master, and the ego to include, the id, is the fact of the maternal care, the maternal ego implementing the infant ego and so making it powerful and stable. How this takes place will need to be examined, and also how the infant ego eventually becomes free of the mother's ego-support, so that the infant achieves mental detachment from the mother, that is, differentiation into a separate personal self.

In order to examine the parent-infant relationship it is necessary first to attempt a brief statement of the theory of infant emotional development.

Historical

In psycho-analytic theory as it grew up the early hypothesis concerned the id and the ego mechanisms of defence. It was understood that the id arrived on the scene very early indeed, and Freud's discovery and description of pregenital sexuality, based on his observations of the regressive elements found in genital fantasy and in play and in dreams, are main features of clinical psychology.

Ego mechanisms of defence were gradually formulated.[1] These mechanisms were assumed to be organized in relation to anxiety which derived either from instinct tension or from object loss. This part of psycho-analytic theory presupposes a separateness of the self and a structuring of the ego, perhaps a personal body scheme. At the level of the main part of this paper this state of affairs cannot yet be assumed. The discussion centres round the establishment of precisely this state of affairs, namely the structuring of the ego which makes anxiety from instinct tension or object loss possible. Anxiety at this early stage is not castration anxiety or separation anxiety; it relates to quite other things, and is, in fact, anxiety about annihilation (cf. the aphanisis of Jones).

In psycho-analytic theory ego mechanisms of defence largely belong to the idea of a child that has an independence, a truly

[1] Researches into defence mechanisms which followed Anna Freud's *The Ego and the Mechanisms of Defence* (1936) have from a different route arrived at a re-evaluation of the role of mothering in infant care and early infant development. Anna Freud (1953) has reassessed her views on the matter. Willi Hoffer (1955) also has made observations relating to this area of development. My emphasis in this paper, however, is on the importance of an understanding of the role of the early parental environment in infant development, and on the way this becomes of clinical significance for us in our handling of certain types of case with affective and character disorders.

personal defence organization. On this borderline the researches of Klein add to Freudian theory by clarifying the interplay of primitive anxieties and defence mechanisms. This work of Klein concerns earliest infancy, and draws attention to the importance of aggressive and destructive impulses that are more deeply rooted than those that are reactive to frustration and related to hate and anger; also in Klein's work there is a dissection of early defences against primitive anxieties, anxieties that belong to the first stages of the mental organization (splitting, projection, and introjection).

What is described in Melanie Klein's work clearly belongs to the life of the infant in its earliest phases, and to the period of dependence with which this paper is concerned. Melanie Klein made it clear that she recognized that the environment was important at this period, and in various ways at all stages.[1] I suggest, however, that her work and that of her co-workers leaves open for further consideration the development of the theme of full dependence, that which appears in Freud's phrase: '. . . the infant, provided one includes with it the care it receives from its mother . . .' There is nothing in Klein's work that contradicts the idea of absolute dependence, but there seems to me to be no specific reference to a stage at which the infant exists only because of the maternal care, together with which it forms a unit.

What I am bringing forward for consideration here is the difference between the analyst's acceptance of the reality of dependence, and his working with it in the transference.[2]

It would seem that the study of ego-defences takes the investigator back to pregenital id-manifestations, whereas the study of ego psychology takes him back to dependence, to the maternal-care–infant unit.

One half of the theory of the parent-infant relationship concerns the infant, and is the theory of the infant's journey from absolute dependence, through relative dependence, to independence, and, in parallel, the infant's journey from the pleasure principle to the reality principle, and from autoerotism to object relationships. The other half of the theory of the parent-infant relationship concerns maternal care, that is to say the qualities and changes in the mother that meet the specific and developing needs of the infant towards whom she orientates.

[1] I have given a detailed account of my understanding of Melanie Klein's work in this area in two papers (Winnicott, 1954b, and Chap. 1 of this volume). See Klein (1946, p. 297).

[2] For a clinical example see my paper, 'Withdrawal and Regression' (1954).

A. THE INFANT

The key word in this part of the study is *dependence*. Human infants cannot start to *be* except under certain conditions. These conditions are studied below, but they are part of the psychology of the infant. Infants come into *being* differently according to whether the conditions are favourable or unfavourable. At the same time conditions do not determine the infant's potential. This is inherited, and it is legitimate to study this inherited potential of the individual as a separate issue, *provided always that it is accepted that the inherited potential of an infant cannot become an infant unless linked to maternal care.*

The inherited potential includes a tendency towards growth and development. All stages of emotional growth can be roughly dated. Presumably all developmental stages have a date in each individual child. Nevertheless, not only do these dates vary from child to child, but also, *even if they were known in advance* in the case of a given child, they could not be used in predicting the child's actual development because of the other factor, maternal care. If such dates could be used in prediction at all, it would be on the basis of assuming a maternal care that is adequate in the important respects. (This obviously does not mean adequate only in the physical sense; the meaning of adequacy and inadequacy in this context is discussed below.)

The Inherited Potential and its Fate

It is necessary here to attempt to state briefly what happens to the inherited potential if this is to develop into an infant, and thereafter into a child, a child reaching towards independent existence. Because of the complexities of the subject such a statement must be made on the assumption of satisfactory maternal care, which means parental care. Satisfactory parental care can be classified roughly into three overlapping stages:

(*a*) Holding.
(*b*) Mother and infant living together. Here the father's function (of dealing with the environment for the mother) is not known to the infant.
(*c*) Father, mother, and infant, all three living together.

The term 'holding' is used here to denote not only the actual physical holding of the infant, but also the total environmental provision prior to the concept of *living with*. In other words, it

refers to a three-dimensional or space relationship with time gradually added. This overlaps with, but is initiated prior to, instinctual experiences that in time would determine object relationships. It includes the management of experiences that are inherent in existence, such as the *completion* (and therefore the *non-completion*) of processes, processes which from the outside may seem to be purely physiological but which belong to infant psychology and take place in a complex psychological field, determined by the awareness and the empathy of the mother. (This concept of holding is further discussed below.)

The term 'living with' implies object relationships, and the emergence of the infant from the state of being merged with the mother, or his perception of objects as external to the self.

This study is especially concerned with the 'holding' stage of maternal care, and with the complex events in infants' psychological development that are related to this holding phase. It should be remembered, however, that a division of one phase from another is artificial, and merely a matter of convenience, adopted for the purpose of clearer definition.

Infant Development During the Holding Phase

In the light of this some characteristics of infant development during this phase can be enumerated. It is at this stage that

primary process
primary identification
auto-erotism
primary narcissism

are living realities.

In this phase the ego changes over from an unintegrated state to a structured integration, and so the infant becomes able to experience anxiety associated with disintegration. The word disintegration begins to have a meaning which it did not possess before ego integration became a fact. In healthy development at this stage the infant retains the capacity for re-experiencing unintegrated states, but this depends on the continuation of reliable maternal care or on the build-up in the infant of memories of maternal care beginning gradually to be perceived as such. The result of healthy progress in the infant's development during this stage is that he attains to what might be called 'unit status'. The infant becomes a person, an individual in his own right.

Associated with this attainment is the infant's psychosomatic existence, which begins to take on a personal pattern; I have

referred to this as the psyche indwelling in the soma.[1] The basis for this indwelling is a linkage of motor and sensory and functional experiences with the infant's new state of being a person. As a further development there comes into existence what might be called a limiting membrane, which to some extent (in health) is equated with the surface of the skin, and has a position between the infant's 'me' and his 'not-me'. So the infant comes to have an inside and an outside, and a body-scheme. In this way meaning comes to the function of intake and output; moreover, it gradually becomes meaningful to postulate a personal or inner psychic reality for the infant.[2]

During the holding phase other processes are initiated; the most important is the dawn of intelligence and the beginning of a mind as something distinct from the psyche. From this follows the whole story of the secondary processes and of symbolic functioning, and of the organization of a personal psychic content, which forms a basis for dreaming and for living relationships.

At the same time there starts in the infant a joining up of two roots of impulsive behaviour. The term 'fusion' indicates the positive process whereby diffuse elements that belong to movement and to muscle erotism become (in health) fused with the orgiastic functioning of the erotogenic zones. This concept is more familiar as the reverse process of defusion, which is a complicated defence in which aggression becomes separated out from erotic experience after a period in which a degree of fusion has been achieved. All these developments belong to the environmental condition of *holding*, and without a good enough holding these stages cannot be attained, or once attained cannot become established.

A further development is in the capacity for object relationships. Here the infant changes from a relationship to a subjectively conceived object to a relationship to an object objectively perceived. This change is closely bound up with the infant's change from being merged with the mother to being separate from her, or to relating to her as separate and 'not-me'. This development is not specifically related to the holding, but is related to the phase of 'living with' . . .

[1] For an earlier statement by me on this issue see my paper, 'Mind and its Relation to the Psyche-Soma' (1949c).

[2] Here the work on primitive fantasy, with whose richness and complexity we are familiar through the teachings of Melanie Klein, becomes applicable and appropriate.

Dependence

In the holding phase the infant is maximally dependent. One can classify dependence thus:

(i) *Absolute Dependence.* In this state the infant has no means of knowing about the maternal care, which is largely a matter of prophylaxis. He cannot gain control over what is well and what is badly done, but is only in a position to gain profit or to suffer disturbance.

(ii) *Relative Dependence.* Here the infant can become aware of the need for the details of maternal care, and can to a growing extent relate them to personal impulse, and then later, in a psycho-analytic treatment, can reproduce them in the transference.

(iii) *Towards Independence.* The infant develops means for doing without actual care. This is accomplished through the accumulation of memories of care, the projection of personal needs and the introjection of care details, with the development of confidence in the environment. Here must be added the element of intellectual understanding with its tremendous implications.

Isolation of the Individual

Another phenomenon that needs consideration at this phase is the hiding of the core of the personality. Let us examine the concept of a central or true self. The central self could be said to be the inherited potential which is experiencing a continuity of being, and acquiring in its own way and at its own speed a personal psychic reality and a personal body-scheme.[1] It seems necessary to allow for the concept of the isolation of this central self as a characteristic of health. Any threat to this isolation of the true self constitutes a major anxiety at this early stage, and defences of earliest infancy appear in relation to failures on the part of the mother (or in maternal care) to ward off impingements which might disturb this isolation.

Impingements may be met and dealt with by the ego organization, gathered into the infant's omnipotence and sensed as projections.[2] On the other hand they may get through this defence in spite of the ego-support which maternal care provides. Then the central core of the ego is affected, and this is the very

[1] In Chapter 2 I have tried to discuss another aspect of this developmental phase as we see it in adult health. Cf. Greenacre (1958).

[2] I am using the term 'projections' here in its descriptive and dynamic and not in its full metapsychological sense. The function of primitive psychic mechanisms, such as introjection, projection, and splitting, falls beyond the scope of this paper.

nature of psychotic anxiety. In health the individual soon becomes invulnerable in this respect, and if external factors impinge there is merely a new degree and quality in the hiding of the central self. In this respect the best defence is the organization of a false self. Instinctual satisfactions and object relationships themselves constitute a threat to the individual's personal going-on-being. *Example:* a baby is feeding at the breast and obtains satisfaction. This fact by itself does not indicate whether he is having an ego-syntonic id experience or, on the contrary, is suffering the trauma of a seduction, a threat to personal ego continuity, a threat by an id experience which is not ego-syntonic, and with which the ego is not equipped to deal.

In health object relationships can be developed on the basis of a compromise, one which involves the individual in what later would be called cheating and dishonesty, whereas a direct relationship is possible only on the basis of regression to a state of being merged with the mother.

Annihilation[1]

Anxiety in these early stages of the parent-infant relationship relates to the threat of annihilation, and it is necessary to explain what is meant by this term.

In this place which is characterized by the essential existence of a holding environment, the 'inherited potential' is becoming itself a 'continuity of being'. The alternative to being is reacting, and reacting interrupts being and annihilates. Being and annihilation are the two alternatives. The holding environment therefore has as its main function the reduction to a minimum of impingements to which the infant must react with resultant annihilation of personal being. Under favourable conditions the infant establishes a continuity of existence and then begins to develop the sophistications which make it possible for impingements to be gathered into the area of omnipotence. At this stage the word death has no possible application, and this makes the term death instinct unacceptable in describing the root of destructiveness. Death has no meaning until the arrival of hate and of the concept of the whole human person. When a whole human person can be hated, death has meaning, and close on this follows that which can be called maiming; the whole hated and loved person is kept alive by being castrated or otherwise maimed instead of killed. These ideas belong to a phase later than that characterized by dependence on the holding environment.

[1] I have described clinical varieties of this type of anxiety from a slightly different aspect in a previous paper (1949b).

Freud's Footnote Re-examined

At this point it is necessary to look again at Freud's statement quoted earlier. He writes: 'Probably it (the baby) hallucinates the fulfilment of its inner needs; it betrays its pain due to increase of stimulation and delay of satisfaction by the motor discharge of crying and struggling, and then experiences the hallucinated satisfaction.' The theory indicated in this part of the statement fails to cover the requirements of the earliest phase. Already by these words reference is being made to object relationships, and the validity of this part of Freud's statement depends on his taking for granted the earlier aspects of maternal care, those which are here described as belonging to the holding phase. On the other hand, this sentence of Freud fits exactly the requirements in the *next* phase, that which is characterized by a relationship between infant and mother in which object relationships and instinctual or erotogenic-zone satisfactions hold sway; that is, when development proceeds well.

B. THE ROLE OF THE MATERNAL CARE

I shall now attempt to describe some aspects of maternal care, and especially holding. In this paper the concept of holding is important, and a further development of the idea is necessary. The word is here used to introduce a full development of the theme contained in Freud's phrase '. . . when one considers that the infant—provided one includes with it the care it receives from its mother—does almost realize a psychical system of this kind'. I refer to the actual state of the infant-mother relationship at the beginning when the infant has not separated out a self from the maternal care on which there exists absolute dependence in a psychological sense.[1]

At this stage the infant needs and in fact usually gets an environmental provision which has certain characteristics:

It meets physiological needs. Here physiology and psychology have not yet become distinct, or are only in the process of doing so; and

It is reliable. But the environmental provision is not mechanically reliable. It is reliable in a way that implies the mother's empathy.

[1] Reminder: to be sure of separating this off from object relationships and instinct-gratification I must *artificially* confine my attention to the body needs of a general kind. A patient said to me: 'A good analytic hour in which the right interpretation is given at the right time *is* a good feed.'

Holding:

Protects from physiological insult.
Takes account of the infant's skin sensitivity—touch, temperature, auditory sensitivity, visual sensitivity, sensitivity to falling (action of gravity) and of the infant's lack of knowledge of the existence of anything other than the self.
It includes the whole routine of care throughout the day and night, and it is not the same with any two infants because it is part of the infant, and no two infants are alike.
Also it follows the minute day-to-day changes belonging to the infant's growth and development, both physical and psychological.

It should be noted that mothers who have it in them to provide good-enough care can be enabled to do better by being cared for themselves in a way that acknowledges the essential nature of their task. Mothers who do not have it in them to provide good-enough care cannot be made good enough by mere instruction.

Holding includes especially the physical holding of the infant, which is a form of loving. It is perhaps the only way in which a mother can show the infant her love. There are those who can hold an infant and those who cannot; the latter quickly produce in the infant a sense of insecurity, and distressed crying.

All this leads right up to, includes, and co-exists with the establishment of the infant's first object relationships and his first experiences of instinctual gratification.[1]

It would be wrong to put the instinctual gratification (feeding etc.) or object relationships (relation to the breast) before the matter of ego organization (i.e. infant ego reinforced by maternal ego). The basis for instinctual satisfaction and for object relationships is the handling and the general management and the care of the infant, which is only too easily taken for granted when all goes well.

The mental health of the individual, in the sense of freedom from psychosis or liability to psychosis (schizophrenia), is laid down by this maternal care, which when it goes well is scarcely noticed, and is a continuation of the physiological provision that characterizes the prenatal state. This environmental provision is also a continuation of the tissue aliveness and the functional health which (for the infant) provides silent but vitally important ego-support. In this way schizophrenia or infantile psychosis or a

[1] For further discussion of this aspect of the developmental processes see my paper, 'Transitional Objects and Transitional Phenomena' (1951).

liability to psychosis at a later date is related to a failure of environmental provision. This is not to say, however, that the ill-effects of such failure cannot be described in terms of ego distortion and of the defences against primitive anxieties, that is to say in terms of the individual. It will be seen, therefore, that the work of Klein on the splitting defence mechanisms and on projections and introjections and so on, is an attempt to state the effects of failure of environmental provision in terms of the individual. This work on primitive mechanisms gives the clue to only one part of the story, and a reconstruction of the environment and of its failures provides the other part. This other part cannot appear in the transference because of the patient's lack of knowledge of the maternal care, either in its good or in its failing aspects, as it existed in the original infantile setting.

Examination of One Detail of Maternal Care

I will give an example to illustrate subtlety in infant care. An infant is merged with the mother, and while this remains true the nearer the mother can come to an exact understanding of the infant's needs the better. A change, however, comes with the end of merging, and this end is not necessarily gradual. As soon as mother and infant are separate, from the infant's point of view, then it will be noted that the mother tends to change in her attitude. It is as if she now realizes that the infant no longer expects the condition in which there is an almost magical understanding of need. The mother seems to know that the infant has a new capacity, that of giving a signal so that she can be guided towards meeting the infant's needs. It could be said that if now she knows too well what the infant needs, this is magic and forms no basis for an object relationship. Here we get to Freud's words: 'It (the infant) probably hallucinates the fulfilment of its internal needs; it betrays its unpleasure, when there is an increase of stimulus and an absence of satisfaction, by the motor discharge of screaming and beating about with its arms and legs, and it then experiences the satisfaction it has hallucinated.' In other words, at the end of merging, when the child has become separate from the environment, an important feature is that the infant has to give a signal.[1] We find this subtlety appearing clearly in the transference in our analytic work. It is very important, except when the patient is regressed to earliest infancy and to a state of merging, that the analyst shall *not* know the answers except in so far as the patient gives the clues. The analyst gathers the clues and makes the interpretations, and it often happens that patients

[1] Freud's later (1926) theory of anxiety as a signal to the ego.

fail to give the clues, making certain thereby that the analyst can do nothing. This limitation of the analyst's power is important to the patient, just as the analyst's power is important, represented by the interpretation that is right and that is made at the right moment, and that is based on the clues and the unconscious co-operation of the patient who is supplying the material which builds up and justifies the interpretation. In this way the student analyst sometimes does better analysis than he will do in a few years' time when he knows more. When he has had several patients he begins to find it irksome to go as slowly as the patient is going, and he begins to make interpretations based not on material supplied on that particular day by the patient but on his own accumulated knowledge or his adherence for the time being to a particular group of ideas. This is of no use to the patient. The analyst may appear to be very clever, and the patient may express admiration, but in the end the correct interpretation is a trauma, which the patient has to reject, because it is not his. He complains that the analyst attempts to hypnotize him, that is to say, that the analyst is inviting a severe regression to dependence, pulling the patient back to a merging in with the analyst.

The same thing can be observed with the mothers of infants; mothers who have had several children begin to be so good at the technique of mothering that they do all the right things at the right moments, and then the infant who has begun to become separate from the mother has no means of gaining control of all the good things that are going on. The creative gesture, the cry, the protest, all the little signs that are supposed to produce what the mother does, all these things are missing, because the mother has already met the need just as if the infant were still merged with her and she with the infant. In this way the mother, by being a seemingly good mother, does something worse than castrate the infant. The latter is left with two alternatives: either being in a permanent state of regression and of being merged with the mother, or else staging a total rejection of the mother, even of the seemingly good mother.

We see therefore that in infancy and in the management of infants there is a very subtle distinction between the mother's understanding of her infant's need based on empathy, and her change over to an understanding based on something in the infant or small child that indicates need. This is particularly difficult for mothers because of the fact that children vacillate between one state and the other; one minute they are merged with their mothers and require empathy, while the next they are separate

from her, and then if she knows their needs in advance she is dangerous, a witch. It is a very strange thing that mothers who are quite uninstructed adapt to these changes in their developing infants satisfactorily and without any knowledge of the theory. This detail is reproduced in psycho-analytic work with borderline cases, and in all cases at certain moments of great importance when dependence in transference is maximal.

Unawareness of Satisfactory Maternal Care

It is axiomatic in these matters of maternal care of the holding variety that when things go well the infant has no means of knowing what is being properly provided and what is being prevented. On the other hand it is when things do not go well that the infant becomes aware, not of the failure of maternal care, but of the results, whatever they may be, of that failure; that is to say, the infant becomes aware of reacting to some impingement. As a result of success in maternal care there is built up in the infant a continuity of being which is the basis of ego-strength; whereas the result of each failure in maternal care is that the continuity of being is interrupted by reactions to the consequences of that failure, with resultant ego-weakening.[1] Such interruptions constitute annihilation, and are evidently associated with pain of psychotic quality and intensity. In the extreme case the infant exists only on the basis of a continuity of reactions to impingement and of recoveries from such reactions. This is in great contrast to the continuity of being which is my conception of ego-strength.

C. THE CHANGES IN THE MOTHER

It is important in this context to examine the changes that occur in women who are about to have a baby or who have just had one. These changes are at first almost physiological, and they start with the physical holding of the baby in the womb. Something would be missing, however, if a phrase such as 'maternal instinct' were used in description. The fact is that in health women change in their orientation to themselves and to the world, but however deeply rooted in physiology such changes may be, they can be distorted by mental ill-health in the

[1] In character cases it is this ego-weakening and the individual's various attempts to deal with it that presents itself for immediate attention, and yet only a true view of the etiology can make possible a sorting out of the defence aspect of this presenting symptom from its origin in environmental failure. I have referred to one specific aspect of this in the diagnosis of the antisocial tendency as the basic problem behind the Delinquency Syndrome (19).

woman. It is necessary to think of these changes in psychological terms and this in spite of the fact that there may be endocrinological factors which can be affected by medication.

No doubt the physiological changes sensitize the woman to the more subtle psychological changes that follow.

Soon after conception, or when conception is known to be possible, the woman begins to alter in her orientation, and to be concerned with the changes that are taking place within her. In various ways she is encouraged by her own body to be interested in herself.[1] The mother shifts some of her sense of self on to the baby that is growing within her. The important thing is that there comes into existence a state of affairs that merits description and the theory of which needs to be worked out.

The analyst who is meeting the needs of a patient who is reliving these very early stages in the transference undergoes similar changes of orientation; and the analyst, unlike the mother, needs to be aware of the sensitivity which develops in him or her in response to the patient's immaturity and dependence. This could be thought of as an extension of Freud's description of the analyst as being in a voluntary state of attentiveness.

A detailed description of the changes in orientation in a woman who is becoming or who has just become a mother would be out of place here, and I have made an attempt elsewhere to describe these changes in popular or non-technical language (Winnicott, 1949a).

There is a psycho-pathology of these changes in orientation, and the extremes of abnormality are the concern of those who study the psychology of puerperal insanity. No doubt there are many variations in quality which do not constitute abnormality. It is the degree of distortion that constitutes abnormality.

By and large mothers do in one way or another identify themselves with the baby that is growing within them, and in this way they achieve a very powerful sense of what the baby needs. This is a projective identification. This identification with the baby lasts for a certain length of time after parturition, and then gradually loses significance.

In the ordinary case the mother's special orientation to the infant carries over beyond the birth process. The mother who is not distorted in these matters is ready to let go of her identification with the infant as the infant needs to become separate. It is possible to provide good initial care, but to fail to complete the process through an inability to let it come to an end, so that the

[1] For a more detailed statement on this point see 'Primary Maternal Preoccupation' (1956).

mother tends to remain merged with her infant and to delay the infant's separation from her. It is in any case a difficult thing for a mother to separate from her infant at the same speed at which the infant needs to become separate from her.[1]

The important thing, in my view, is that the mother through identification of herself with her infant knows what the infant feels like and so is able to provide almost exactly what the infant needs in the way of holding and in the provision of an environment generally. Without such an identification I consider that she is not able to provide what the infant needs at the beginning, which is *a live adaptation to the infant's needs*. The main thing is the physical holding, and this is the basis of all the more complex aspects of holding, and of environmental provision in general.

It is true that a mother may have a baby who is very different from herself so that she miscalculates. The baby may be quicker or slower than she is, and so on. In this way there may be times when what she feels the baby needs is not in fact correct. However, it seems to be usual that mothers who are not distorted by ill-health or by present-day environmental stress do tend on the whole to know accurately enough what their infants need, and further, they like to provide what is needed. This is the essence of maternal care.

With 'the care that it receives from its mother' each infant is able to have a personal existence, and so begins to build up what might be called *a continuity of being*. On the basis of this continuity of being the inherited potential gradually develops into an individual infant. If maternal care is not good enough then the infant does not really come into existence, since there is no continuity of being; instead the personality becomes built on the basis of reactions to environmental impingement.

All this has significance for the analyst. Indeed it is not from direct observation of infants so much as from the study of the transference in the analytic setting that it is possible to gain a clear view of what takes place in infancy itself. This work on infantile dependence derives from the study of the transference and counter-transference phenomena that belong to the psychoanalyst's involvement with the borderline case. In my opinion this involvement is a legitimate extension of psycho-analysis, the only real alteration being in the diagnosis of the illness of the patient, the etiology of whose illness goes back behind the Oedipus complex, and involves a distortion at the time of absolute dependence.

[1] Case-material to illustrate one type of problem that is met with clinically and relates to this group of ideas is presented in an earlier paper (1948).

Freud was able to discover infantile sexuality in a new way because he reconstructed it from his analytic work with psychoneurotic patients. In extending his work to cover the treatment of the borderline psychotic patient it is possible for us to reconstruct the dynamics of infancy and of infantile dependence, and the maternal care that meets this dependence.

Summary

(i) An examination is made of infancy; this is not the same as an examination of primitive mental mechanisms.

(ii) The main feature of infancy is dependence; this is discussed in terms of the holding environment.

(iii) Any study of infancy must be divided into two parts:

(*a*) Infant development facilitated by good-enough maternal care;

(*b*) Infant development distorted by maternal care that is not good enough.

(iv) The infant ego can be said to be weak, but in fact it is strong because of the ego support of maternal care. Where maternal care fails the weakness of the infant ego becomes apparent.

(v) Processes in the mother (and in the father) bring about, in health, a special state in which the parent is orientated to the infant, and is thus in a position to meet the infant's dependence. There is a pathology of these processes.

(vi) Attention is drawn to the various ways in which these conditions inherent in what is here termed the holding[1] environment can or cannot appear in the transference if at a later date the infant should come into analysis.

[1] Concept of 'holding' in case work: Cf. Winnicott, Clare [1954].

4

EGO INTEGRATION IN CHILD DEVELOPMENT

(1962)

The term ego can be used to describe that part of the growing human personality that tends, under suitable conditions, to become integrated into a unit.

In the body of an anencephalic infant functional events, including instinctual localizations, may be taking place, events that would be called experiences of id-function if there were a brain. It could be said that if there had been a normal brain there would have been an organization of these functions, and to this organization could have been given the label ego. But with no electronic apparatus there can be no experience, and therefore no ego.

But id-functioning is normally not lost; it is collected together in all its aspects and becomes ego-experience. There is thus no sense in making use of the word 'id' for phenomena that are not covered and catalogued and experienced and eventually interpreted by ego-functioning.

In the very early stages of the development of a human child, therefore, ego-functioning needs to be taken as a concept that is inseparable from that of the existence of the infant as a person. What instinctual life there may be apart from ego-functioning can be ignored, because the infant is not yet an entity having experiences. There is no id before ego. Only from this premise can a study of the ego be justified.

It will be seen that the ego offers itself for study long before the word self has relevance. The word self arrives after the child has begun to use the intellect to look at what others see or feel or hear and what they conceive of when they meet this infant body. (The concept of the self will not be studied in this chapter.)

The first question that is asked about that which is labelled ego is this: is there an ego from the start? The answer is that the start is when the ego starts.[1]

Then *the second question* arises: is the ego strong or weak? The answer to this second question depends on the actual mother and

[1] It is well to remember that the beginning is a summation of beginnings.

her ability to meet the absolute dependence of the actual infant at the beginning, at the stage before the infant has separated out the mother from the self.

In my terminology the good-enough mother is able to meet the needs of her infant at the beginning, and to meet these needs so well that the infant, as emergence from the matrix of the infant-mother relationship takes place, is able to have a brief *experience of omnipotence*. (This has to be distinguished from *omnipotence*, which is the name given to a quality of feeling.)

The mother can do this because of her having temporarily given herself over to the one task, that of the care of this one infant. Her task is made possible by the fact that the baby has a capacity, when this matter of the mother's supportive ego-function is operative, to relate to *subjective objects*. In this respect the baby can meet the reality principle here and there, now and then, but not everywhere all at once; that is, the baby retains areas of subjective objects along with other areas in which there is some relating to objectively perceived objects, or 'not-me' ('non-I') objects.

So much difference exists between the beginning of a baby whose mother can perform this function well enough and that of a baby whose mother cannot do this well enough that there is no value whatever in describing babies in the earliest stages except in relation to the mother's functioning. When there is not-good-enough mothering the infant is not able to get started with ego-maturation, or else ego-development is necessarily distorted in certain vitally important respects.

It must be understood that when reference is made to the mother's adaptive capacity this has only a little to do with her ability to satisfy the infant's oral drives, as by giving a satisfactory feed. What is being discussed here runs parallel with such a consideration as this. It is indeed possible to gratify an oral drive and by so doing to *violate* the infant's ego-function, or that which will later on be jealously guarded as the self, the core of the personality. A feeding satisfaction can be a seduction and can be traumatic if it comes to a baby without coverage by ego-functioning.

At the stage which is being discussed it is necessary not to think of the baby as a person who gets hungry, and whose instinctual drives may be met or frustrated, but to think of the baby as an immature being who is all the time *on the brink of unthinkable anxiety*. Unthinkable anxiety is kept away by this vitally important function of the mother at this stage, her capacity to put herself in the baby's place and to know what the baby needs in the general management of the body, and therefore

of the person. Love, at this stage, can only be shown in terms of body-care, as in the last stage before full-term birth.

Unthinkable anxiety has only a few varieties, each being the clue to one aspect of normal growth.

(1) Going to pieces.
(2) Falling for ever.
(3) Having no relationship to the body.
(4) Having no orientation.

It will be recognized that these are specifically the stuff of the psychotic anxieties, and these belong, clinically, to schizophrenia, or to the emergence of a schizoid element hidden in an otherwise non-psychotic personality.

From here it is necessary to interrupt the sequence of ideas in order to examine the fate of the baby who misses good-enough care in the early stage before the baby has separated off the 'not-me' from the 'me'. This is a complex subject because of all the degrees and varieties of maternal failure. It is profitable, first, to refer to:

(1) distortions of the ego-organization that lay down the basis for schizoid characteristics, and

(2) the specific defence of self-holding, or the development of a caretaker self and the organization of an aspect of the personality that is false (false in that what is showing is a derivative not of the individual but of the mothering aspect of the infant-mother coupling). This is a defence whose success may provide a new threat to the core of the self though it is designed to hide and protect this core of the self.

The consequences of defective ego support by the mother can be very severely crippling, and include the following:

A. *Infantile Schizophrenia or Autism*

This well-known clinical grouping contains disorder secondary to physical brain lesions or deficiency, and also includes some degree of every kind of failure of the earliest maturational details. In a proportion of cases there is no evidence of neurological defect or disease.

It is a common experience in child psychiatry for the clinician to be unable to decide between a diagnosis of primary defect, mild Little's disease, pure psychological failure of early maturation in a child with brain intact, or a mixture of two or all of these. In some cases there is good evidence of a reaction to failure of ego-support of the kind I am describing in this chapter.

B. *Latent Schizophrenia*

There are many clinical varieties of latent schizophrenia in children who pass for normal, or who may even show special brilliance of intellect or precocious performance. The illness shows in the brittleness of the 'success'. Strain and stress at later stages of development may trigger off an illness.

C. *False Self-defence*

The use of defences, especially that of a successful false self, enables many children to seem to give good promise, but eventually a breakdown reveals the fact of the true self's absence from the scene.

D. *Schizoid Personality*

Commonly there develops personality disorder which depends on the fact that a schizoid element is hidden in a personality that is otherwise sane. Serious schizoid elements become socialized in so far as they can hide in a pattern of schizoid disorder that is accepted in a person's local culture.

These degrees and kinds of personality defects can be related, in investigations of individual cases, to various kinds and degrees of failure of holding, handling and object-presenting at the earliest stage. This is not to deny the existence of hereditary factors, but rather to supplement them in important respects.

Ego development is characterized by various trends:

(1) The main trend in the maturational process can be gathered into the various meanings of the word *integration*. Integration in time becomes added to (what might be called) integration in space.

(2) The ego is based on a body ego, but it is only when all goes well that the person of the baby starts to be linked with the body and the body-functions, with the skin as the limiting membrane. I have used the term *personalization* to describe this process, because the term depersonalization seems at basis to mean a loss of firm union between ego and body, including id-drives and id-satisfactions. (The term depersonalization has gathered to itself a more sophisticated meaning in psychiatric writings.)

(3) The ego *initiates object-relating*. With good-enough mothering at the beginning the baby is not subjected to instinctual gratifications except in so far as there is ego-participation. In this respect it is not so much a question of giving the baby satisfaction

as of letting the baby find and come to terms with the object (breast, bottle, milk, etc.).

When we attempt to assess what Sechehaye (1951) did when she gave her patient an apple at the right moment (symbolic realization) it is of but little moment whether the patient ate the apple, or just looked at it, or took it and kept it. The important thing was that the patient was able to create an object, and Sechehaye did no more than enable the object to take apple-shape, so that the girl had created a part of the actual world, an apple.

It would seem to be possible to match these three phenomena of ego-growth with three aspects of infant and child-care:

Integration matches with holding.
Personalization matches with handling.
Object-relating matches with object-presenting.

This leads to a consideration of two problems associated with the idea of integration:

(1) *Integration from what?*

It is useful to think of the material out of which integration emerges in terms of motor and sensory elements, the stuff of primary narcissism. This would acquire a tendency towards a sense of existing. Other language can be used to describe this obscure part of the maturational process, but the rudiments of an imaginative elaboration of pure body-functioning must be postulated if it is to be claimed that this new human being has started to be, and has started to gather experience that can be called personal.

(2) *Integration with what?*

All this tends towards the establishment of a unit self, but it cannot be over-emphasized that what happens at this very early stage depends on the ego-coverage given by the mother of the infant-mother coupling.

It can be said that good-enough ego-coverage by the mother (in respect of the unthinkable anxieties) enables the new human person to build up a personality on the pattern of a continuity of going-on-being. All failures (that could produce unthinkable anxiety) bring about a reaction of the infant, and this reaction cuts across the going-on-being. If reacting that is disruptive of going-on-being recurs persistently it sets going a pattern of fragmentation of being. The infant whose pattern is

one of fragmentation of the line of continuity of being has a developmental task that is, almost from the beginning, loaded in the direction of psychopathology. Thus there may be a very early factor (dating from the first days or hours of life) in the aetiology of restlessness, hyperkinesis, and inattentiveness (later called inability to concentrate).

It is pertinent here to state that, whatever the external factors, it is the individual's view (fantasy) of the external factor that counts. Alongside this it is necessary to remember, however, that there is a stage before the individual has repudiated the not-me. So that there is, at this very early stage, no external factor; the mother is part of the child. At this stage the infant's pattern includes the infant's experience of the mother, as she is in her personal actuality.

The opposite of integration would seem to be disintegration. This is only partly true. The opposite, initially, requires a word like unintegration. Relaxation for an infant means not feeling a need to integrate, the mother's ego-supportive function being taken for granted. The understanding of unexcited states requires further consideration in terms of this theory.

The term disintegration is used to describe a sophisticated *defence*, a defence that is an active production of chaos in defence against unintegration in the absence of maternal ego-support, that is, against the unthinkable or archaic anxiety that results from failure of holding in the stage of absolute dependence. The chaos of disintegration may be as 'bad' as the unreliability of the environment, but it has the advantage of being produced by the baby and therefore of being non-environmental. It is within the area of the baby's omnipotence. In terms of psycho-analysis, it is analysable, whereas the unthinkable anxieties are not.

Integration is closely linked with the environmental function of holding. The achievement of integration is the unit. First comes 'I' which includes 'everything else is not me'. Then comes 'I am, I exist, I gather experiences and enrich myself and have an introjective and projective interaction with the NOT-ME, the actual world of shared reality'. Add to this: 'I am seen or understood to exist by someone'; and, further, add to this: 'I get back (as a face seen in a mirror) the evidence I need that I have been recognized as a being.'

In favourable circumstances the skin becomes the boundary between the me and the not-me. In other words, the psyche has come to live in the soma and an individual psycho-somatic life has been initiated.

The establishment of a state of I AM, along with the achievement of psycho-somatic indwelling or cohesion, constitutes a state of affairs which is accompanied by a specific anxiety affect that has an expectation of persecution. This persecutory reaction is inherent in the idea of the repudiation of the 'not-me', which goes with the limitation of the unit self in the body, with the skin as the limiting membrane.

In psycho-somatic illness of one kind there is in the symptomatology an insistence on the interaction of psyche and soma, this being maintained as a *defence* against threat of a loss of psycho-somatic union, or against a form of depersonalization.

Handling describes the environmental provision that corresponds loosely with the establishment of a psycho-somatic partnership. Without good-enough active and adaptive handling the task from within may well prove heavy, indeed it may actually prove impossible for this development of a psycho-somatic inter-relationship to become properly established.

The initiation of object-relating is complex. It cannot take place except by the environmental provision of object-presenting, done in such a way that the baby creates the object. The pattern is thus: the baby develops a vague expectation that has origin in an unformulated need. The adaptive mother presents an object or a manipulation that meets the baby's needs, and so the baby begins to need just that which the mother presents. In this way the baby comes to feel confident in being able to create objects and to create the actual world. The mother gives the baby a brief period in which omnipotence is a matter of experience. It must be emphasized that in referring to the initiating of object-relating I am not referring to id-satisfactions and id-frustrations. I am referring to the preconditions, internal to the child as well as external, conditions which make an ego-experience out of a satisfactory breast feed (or a reaction to frustration).

Summary

My object is to make a bare-bone statement of my conception of the beginnings of the ego. I use the concept of ego-integration, and the place of ego-integration in the initiation of emotional development in the human child, in the child who is all the time moving from absolute dependence to relative dependence, and towards independence. I also trace the beginnings of object-relating within the framework of a baby's experience and growth.

Further, I attempt to assess the importance of the actual environment at the earliest stage, that is, before the baby has

separated out the not-me from the me. I contrast the ego-strength of the baby who gets ego-support from the mother's actual adaptive behaviour, or love, with the ego-weakness of the baby for whom environmental provision is defective at this very early stage.

5

PROVIDING FOR THE CHILD IN HEALTH AND IN CRISIS[1]

(1962)

The subject is a wide one. I propose therefore to select certain features that can be stated easily and that can be put forward as significant, noting in particular those aspects of this general question that belong to the present age.

1. When we think of providing for health we nowadays think in terms of mental health. It is the emotional development of the child that concerns us, and the laying down of the foundations of a lifetime of mental health. The reason for this is that in paediatrics the developments on the physical side have been so great that we know where we are. There is bodily development that takes place, given good heredity, as a result of good food and good physical conditions. We understand the meaning of the words 'good food', and deficiency diseases are now rare. Also, when starvation or poor housing conditions are a feature, we have a social conscience, and we know what to do. In Great Britain this has crystallized out into the welfare state, which with all its drawbacks and the new problems it creates makes us rather pleased as well as annoyed when we pay heavy taxes.

In considering this subject, then, let us take it for granted either that the children we refer to are as healthy physically as modern physical prophylaxis and therapy can ensure; or else that any physical disease that is present is under paediatric control, and that our aim is to study the mental health of the child with that illness. For simplicity's sake we start with the mental health of the physically healthy child.

Of course, if a child suffers from anorexia nervosa the starvation that results is not to be attributed to physical neglect. If there is a so-called 'problem family', then it is not the local authority that can be wholly blamed for the slum conditions in which a child is being brought up. Physical care is affected by the child's or the parents' ability to receive care, and we see that all around the edge of the area that we call physical care there is

[1] Presented in a Panel Discussion organized by the Extension Division Workshop of the San Francisco Psychoanalytic Institute, October 1962.

the complex territory of emotional disorder in the individual, or in groups of individuals, or in society.

2. Providing for the child is therefore a matter of providing the environment that facilitates individual mental health and emotional development. We really do know today a great deal about the way adults grow out of children and children out of infants, and a first principle is that health is maturity, maturity at age.

Emotional development takes place in the individual child if good-enough conditions are provided, and the drive to development comes from within the child. The forces towards living, towards integration of the personality, towards independence, are immensely strong, and with good-enough conditions the child makes progress; when conditions are not good enough these forces are contained within the child, and in one way or another tend to destroy the child.

We have a dynamic view of childhood development, and we see this becoming converted (in healthy conditions) into the family and social drives.

3. If health is maturity, then immaturity of any kind is mental ill health, and is a threat to the individual and a drain on society. For whereas society can use individual aggressive tendencies it cannot use individual immaturities. If we consider what we must provide here we see that we must add:

(i) toleration of individual immaturity and mental ill-health;
(ii) therapy;
(iii) prophylaxis.

4. Immediately I want to put in a word to counteract any impression I may have given that health is enough. We are not only concerned with individual maturity and with the freedom of individuals from mental disorder or from psycho-neurosis; we are concerned with the richness of individuals in terms not of money but of inner psychic reality. Indeed, we often forgive a man or woman for mental ill-health or for some kind of immaturity because that person has so rich a personality that society may gain much through the exceptional contribution he or she can make. May I say that Shakespeare's contribution was such that we would not mind much if we found that he was immature, or homosexual, or antisocial in some localized sense. This principle can be applied in a broad way and I need not labour the point. A research project, for instance, might show by significant statistics that infants who are bottle-fed are physically healthier

and even, perhaps, less liable to mental disorder than those who are not. But we are concerned also with the richness of the breast-feeding experience in comparison with its alternative, if this affects the richness of the personality potential of the infant now grown to childhood and to adult life.

It is enough if I have made it clear that we aim at providing more than healthy conditions to produce health. Richness of quality rather than health is at the top of the ladder of human progress.

5. We discuss providing for the child—and for the child in the adult. The mature adult is in fact taking part in the providing. In other words, childhood is a progression from dependence to independence. We need to examine the changing needs of the child as dependence changes over into independence. This leads us to a study of the very early needs of small children and of infants, and to the extremes of dependence. We can think of the degrees of dependence as a series:

(*a*) *Extreme dependence.* Here conditions must be good enough, otherwise the infant cannot start the development that is born with him.
Environmental failure: Mental defect non-organic; childhood schizophrenia; liability to mental-hospital disorder at a later date.

(*b*) *Dependence.* Here conditions that fail do in fact traumatize, but there is already a person there to be traumatized.
Environmental failure: Liability to affective disorders; antisocial tendency.

(*c*) *Dependence-independence mixtures.* Here the child is making experiments in independence, but needs to be able to re-experience dependence.
Environmental failure: Pathological dependence.

(*d*) *Independence-dependence.* This is the same, but with the accent on independence.
Environmental failure: Defiance; outbreaks of violence.

(*e*) *Independence.* Implying an internalized environment: an ability on the part of the child to look after himself or herself.
Environmental failure: Not necessarily harmful.

(*f*) *Social sense.* Here it is implied that the individual can identify with adults and with a social group, or with society, without too great a loss of personal impulse and

originality, and without too much loss of the destructive and aggressive impulses that have, presumably, found satisfactory expression in displaced forms.

Environmental failure: Partly the responsibility of the individual, himself or herself a parent, or a parent-figure in society.

6. It is of course a gross over-simplification to say that health is maturity (at age). The story of the emotional development of a child is tremendously complicated, and it is more complex even than we know. We cannot put what we know into a few words, and we cannot agree exactly in regard to details. But that does not matter. Infants and children have been growing and developing satisfactorily for centuries, that is, apart from progress in our intellectual understanding of childhood. But we do need to try to get at a theory of normal growth so as to be able to understand illness and the various immaturities, since we are now no longer contented unless we can cure and prevent. We do not accept childhood schizophrenia any more than we accept poliomyelitis or the condition of the spastic child. We try to prevent, and we hope to be able to lead the way to cure wherever there is abnormality, which means suffering for someone.

It is necessary to say, however, that if one first accepts heredity, then:

(*a*) Good-enough environmental provision really does tend to prevent psychotic or schizophrenic disorder; but
(*b*) with all the good care in the world the individual child is liable to the disturbances associated with conflict arising out of the instinctual life.

In regard to (*b*): the child who is healthy enough to reach the triangular situations as between whole people at the toddler age, when (as later at adolescence) the instinctual life is at its nodal point of intense expression, such a child is subject to conflicts, and to some extent these show clinically as anxiety and in the form of defences organized against anxiety. These defences occur in health, but when rigid they constitute the symptom-formations of psycho-neurotic (not psychotic) illness.

So in health personal difficulties have to be resolved within the child, and cannot be prevented by good management. Earlier distortions, on the other hand, can be prevented.

It is difficult to state this without being misunderstood. Whatever stage of development one is considering it is always the

individual baby's or child's personal conflicts that are the central theme. It is the innate tendencies towards integration and growth that produce the health, not the environmental provision. Yet good-enough provision is necessary, absolutely at the beginning, and relatively at later stages, at the stage of the Oedipus complex, in the latency period, and also at adolescence. I have tried to find words that indicate a lessening degree of dependence on environmental provision.

7. In order to avoid overloading this section with a statement of the theory of emotional development, it is convenient to refer to the essential stages in the following way:

(i) Development in terms of the instinctual life (*id*), i.e. in terms of object relationships.
(ii) Development in terms of personality structure (*ego*), i.e. in terms of what exists for experiencing instinctual drives and the object relationships that have the instinctual drives as a basis.

(i) In the theory by which we work there is a now well-known progression from an alimentary instinctual life to a genital instinctual life. The latency period marks the end of a growth period which will be resumed at puberty. In health the four-year-old child has it in him or her to experience an identification with both parents in their instinctual relationships, but this experience is complete only in play and in dreams, and through the use of symbolism. At puberty the child's growth adds to all this the physical capacity for genital experience and also for actual killing. This is the central theme of personal childhood development.
(ii) Certain tendencies in personality growth are characterized by the fact that they can be discerned from the very beginning, and they never reach completion. I refer to such things as:

(*a*) Integration, including time-integration.
(*b*) What might be called 'in-dwelling': the achievement of a close and easy relationship between the psyche and the body, and body functioning.
(*c*) The development of a capacity to make relationships with objects in spite of the fact that in one sense, and an important sense, the individual is an isolated phenomenon and defends this isolation at all costs.
(*d*) Tendencies that gradually reveal themselves in health, such as the tendency towards independence (to which I have

already referred); the capacity for a sense of concern and guilt; the capacity to love and to like the same persons; and the capacity for happiness at appropriate times.

In discussing provision for mental health it is more profitable to give consideration to (ii) than to (i). The vitally important details of (i) can be left to take care of themselves, and if they go awry then the child needs a psychotherapist. In regard to the processes grouped together in (ii), however, what we provide goes on being important as the child grows, and indeed never ceases, and joins up with the provisions that concern those who care for the aged. In other words, it will profit us to look at the needs of infants, and then to translate these needs into language that is appropriate at all ages.

To make my meaning clear, when we provide a swimming pool and all that goes with it, this provision links with the care with which a mother baths her infant, and with which she generally caters for the infant's need for bodily movement and expression, and for muscle and skin experiences that give satisfactions. It also links with the provision that is appropriate in the therapeutics of certain illnesses. On the one hand it links with the occupational therapy that has great value at certain stages in the treatment of the mentally ill; and, on the other, it links with the physiotherapy that is appropriate, for instance, in the care of spastic children.

In all these cases—the normal child, the infant, the mentally ill person, and the spastic or handicapped—the provision is facilitating the child's innate tendency to inhabit the body and to enjoy the body's functions, and to accept the limitation that the skin provides, a limiting membrane, separating me from not-me.

8. While we try to understand all this we also want to try to understand why a mother (I include father) does not have to have an intellectual understanding of the infant's needs. An intellectual understanding of such needs is of no use to her, and throughout the ages mothers have met their infants' needs adequately, by and large.

In my writings I have made a special feature of this. I think we must allow for a feature of motherhood which finds a reflection in our own need to become preoccupied with any task if we are to do it well. In concentrating or in becoming preoccupied, we can be said to become withdrawn, moody, anti-social, or just irritable, according to our pattern. I think that this is a pale reflection of the thing that happens to mothers, if they are well enough (as

most are) to surrender to motherhood. They become more and more closely identified with the baby, and this they retain when the baby is born, but they gradually lose it in the few months following the baby's birth. Because of this identification with the baby they more or less know what the baby needs. I refer to vital things like being held, being turned over, being put down and taken up, being handled, and of course being fed in a sensitive way which involves more than the satisfaction of an instinct. All these things facilitate the early stages of the infant's integrative tendencies and the beginning of ego structuring. One might say that the mother makes the baby's weak ego into a strong one, because she is there, reinforcing everything, like power-assisted steering on a motor-bus.

I have spent some time on this because I think that any mother, if she knew it (and I do not much want her to), has something to teach us in our efforts to go on providing for the needs of individuals, so that their natural processes can develop momentum. The pattern is that by some degree of capacity to identify with the individual we can provide what an individual needs at any one moment. It is only we who know that there exists something that can meet this need.

I remember when I was four years old I woke up on Christmas morning and found I possessed a blue cart made in Switzerland, like those that the people there use for bringing home wood. How did my parents know that this was exactly what I wanted? Certainly I did not know that such heavenly carts existed. Of course, they knew because of their capacity to feel my feelings, and they knew about the carts because they had been to Switzerland. This leads on to Sechehaye's 'symbolic realization', the central feature in the treatment of schizophrenia of the kind in which inability to make object relationships is a main feature.[1] Sechehaye knew about the patient's need and she also knew where to find a ripe apple. It is the same as the mother's presenting a breast to the infant and, later on, introducing hard objects to the infant, and the fruits of the earth, and father, not creating the infant's needs, but meeting these needs at the right moment.

We, like the mother, must know the importance of:

continuity of the human environment, and likewise of the non-human environment, which helps with the integration of the individual personality;
reliability, which makes mother's behaviour predictable;

[1] Sechehaye, M. A. (1951), *Symbolic Realization*. New York: International Universities Press.

graduated adaptation to the changing and expanding needs of the child, whose growth processes impel him or her towards independence and adventure;
provision for realizing the child's creative impulse.

Further, the mother knows she must keep alive and allow the baby to feel and hear her aliveness. She knows she must postpone her own impulses until the time when the child is able to use her separate existence in a positive way. She knows she must not leave her child for more minutes, hours, days than the child is able to keep the idea of her alive and friendly. If she must be away too long she knows that for some time she will have to change from a mother into a therapist, that is to say, she will have to 'spoil' her child in order to turn the child back (if it is not too late) to a state in which he or she takes the mother for granted again. This links with the provision that we make in meeting crisis—that is apart from supplying psycho-analysis, which is quite another subject.

In this context I go back to 5(*b*) above, which covers the point that separation of a one- or two-year-old child from the mother, beyond the capacity of the child to keep alive the idea of her, produces a state that may later appear as an antisocial tendency. The inner working of this is complex, but the continuity of the child's object relationships has been broken, and development is held up. When the child tries to reach back over the gap this is called stealing.

To do her job well the mother needs outside support; usually the husband shields her from external reality and so enables her to protect her child from unpredictable external phenomena to which the child must react; and it must be remembered that each reaction to an impingement breaks the continuity of the child's personal existing, and goes against the process of integration.

But, broadly speaking, to study what we provide in health and in crisis we can best study the mother (always, I include the father), and what comes naturally to her to provide for her infant. We find that the main feature is that she knows about the infant's needs *through her identification with the infant.* In other words, we find that she does not have to make a sort of shopping list of things she must do tomorrow; she feels what is needed at the moment.

In the same way we do not have to plan the details of what we must provide for children in our care. *We do have to organize ourselves so that in every case there is someone who has time and inclination*

to know what the child needs. This can be known on the basis of someone knowing the child. The identification with the child does not have to be as deep as that of the mother with the newborn baby, except of course when the child under consideration is ill—emotionally immature or distorted, or under handicap because of a physical disorder. When the child is ill, then there is a crisis, and the therapy that is needed involves the therapist personally, and the work cannot be done on any other basis.

Summary

I have attempted to relate the needs of children to those of babies, and to relate the needs of children in crisis to those of babies, and to relate what we provide in child care to that which is provided naturally by parents (that is, unless they are too ill to respond to the call of parenthood). We need not think then of being clever, or even of knowing all the complex theory of the emotional development of the individual. Rather, we need to give opportunity for the right kind of people to get to know the children themselves and so to feel their needs. One could use the word 'love' here, at risk of sounding sentimental.

And this leads on to a final observation: often, without leaving the area covered by the word love, we shall find that a child needs firm management, needs to be treated as the child he or she is, and not as an adult.

6

THE DEVELOPMENT OF THE CAPACITY FOR CONCERN[1]

(1963)

The origin of the capacity to be concerned presents a complex problem. Concern is an important feature in social life. Psychoanalysts usually seek origins in the emotional development of the individual. We want to know the aetiology of concern, and the place where concern appears in the child's development. We also are interested in the failure of the establishment of an individual's capacity for concern, and in the loss of concern that has to some extent been established.

The word 'concern' is used to cover in a positive way a phenomenon that is covered in a negative way by the word 'guilt'. A sense of guilt is anxiety linked with the concept of ambivalence, and implies a degree of integration in the individual ego that allows for the retention of good object-imago along with the idea of a destruction of it. Concern implies further integration, and further growth, and relates in a positive way to the individual's sense of responsibility, especially in respect of relationships into which the instinctual drives have entered.

Concern refers to the fact that the individual *cares*, or *minds*, and both feels and accepts responsibility. At the genital level in the statement of the theory of development, concern could be said to be the basis of the family, where both partners in intercourse—beyond their pleasure—take responsibility for the result. But in the total imaginative life of the individual, the subject of concern raises even wider issues, and a capacity for concern is at the back of all constructive play and work. It belongs to normal, healthy living, and deserves the attention of the psycho-analyst.

There is much reason to believe that concern—with its positive sense—emerges in the earlier emotional development of the child at a period before the period of the classical Oedipus complex, which involves a relationship between three persons, each felt to be a whole person by the child. But there is no need to be precise about timing, and indeed most of the processes that start

[1] Presented to The Topeka Psychoanalytic Society, 12 October 1962, and first published in the *Bulletin of the Menninger Clinic*, **27**, pp. 167–76.

up in early infancy are never fully established, and continue to be strengthened by the growth that continues in later childhood, and indeed in adult life, even in old age.

It is usual to describe the origin of the capacity for concern in terms of the infant-mother relationship, when already the infant is an established unit, and when the infant feels the mother, or mother-figure, to be a whole person. It is a development belonging essentially to the period of a two-body relationship.

In any statement of child-development, certain principles are taken for granted. Here I wish to say that the maturation processes form the basis of infant- and child-development, in psychology as in anatomy and physiology. Nevertheless, in emotional development it is clear that certain external conditions are necessary if maturation potentials are to become actual. That is, development depends on a good-enough environment, and the earlier we go back in our study of the baby, the more true it is that without good-enough mothering the early stages of development cannot take place.

A great deal has happened in the development of the baby before we begin to be able to refer to concern. The capacity to be concerned is a matter of health, a capacity which, once established, presupposes a complex ego-organization which cannot be thought of in any way but as an achievement, both an achievement of infant- and child-care and an achievement in terms of the internal growth-processes in the baby and child. I shall take for granted a good-enough environment in the early stages, in order to simplify the matter that I wish to examine. What I have to say, then, follows on complex maturational processes dependent for their becoming realized on good-enough infant- and child-care.

Of the many stages that have been described by Freud and the psycho-analysts who have followed him, I must single out one stage which has to involve the use of the word 'fusion'. This is the achievement of emotional development in which the baby experiences erotic and aggressive drives toward the same object at the same time. On the erotic side there is both satisfaction-seeking and object-seeking, and on the aggressive side, there is a complex of anger employing muscle erotism, and of hate, which involves the retention of a good object-imago for comparison. Also in the whole aggressive-destructive impulse is contained a primitive type of object relationship in which love involves destruction. Some of this is necessarily obscure, and I do not need to know all about the origin of aggression in order to follow my argument, because I am taking it for granted that the baby

has become able to combine erotic and aggressive experience, and in relation to one object. Ambivalence has been reached.

By the time that this becomes a fact in the development of a child, the infant has become able to experience ambivalence in fantasy, as well as in body-function of which the fantasy is originally an elaboration. Also, the infant is beginning to relate himself to objects that are less and less subjective phenomena, and more and more objectively perceived 'not-me' elements. He has begun to establish a self, a unit that is both physically contained in the body's skin and that is psychologically integrated. The mother has now become—in the child's mind—a coherent image, and the term 'whole object' now becomes applicable. This state of affairs, precarious at first, could be nicknamed the 'humpty-dumpty stage', the wall on which Humpty Dumpty is precariously perched being the mother who has ceased to offer her lap.

This development implies an ego that begins to be independent of the mother's auxiliary ego, and there can now be said to be an inside to the baby, and therefore an outside. The body-scheme has come into being and quickly develops complexity. From now on, the infant lives a psychosomatic life. The inner psychic reality which Freud taught us to respect now becomes a real thing to the infant, who now feels that personal richness resides within the self. This personal richness develops out of the simultaneous love-hate experience which implies the achievement of ambivalence, the enrichment and refinement of which leads to the emergence of concern.

It is helpful to postulate the existence for the immature child of two mothers—shall I call them the object-mother and the environment-mother? I have no wish to invent names that become stuck and eventually develop a rigidity and an obstructive quality, but it seems possible to use these words 'object-mother' and 'environment-mother' in this context to describe the vast difference that there is for the infant between two aspects of infant-care, the mother as object, or owner of the part-object that may satisfy the infant's urgent needs, and the mother as the person who wards off the unpredictable and who actively provides care in handling and in general management. What the infant does at the height of id-tension and the use thus made of the object seems to me very different from the use the infant makes of the mother as part of the total environment.[1]

In this language it is the environment-mother who receives all

[1] This is a theme that has recently been developed in a book by Harold Searles (1960).

that can be called affection and sensuous co-existence; it is the object-mother who becomes the target for excited experience backed by crude instinct-tension. It is my thesis that concern turns up in the baby's life as a highly sophisticated experience in the coming-together in the infant's mind of the object-mother and the environment-mother. The environmental provision continues to be vitally important here, though the infant is beginning to be able to have that inner stability that belongs to the development of independence.

In favourable circumstances, when the baby has reached the necessary stage in personal development, there comes about a new fusion. For one thing, there is the full experience of, and fantasy of, object-relating based on instinct, the object being used without regard for consequences, used ruthlessly (if we use the term as a description of our view of what is going on). And alongside this is the more quiet relationship of the baby to the environment-mother. These two things come together. The result is complex, and it is this that I especially wish to describe.

The favourable circumstances necessary at this stage are these: that the mother should continue to be alive and available, available physically and available in the sense of not being preoccupied with something else. The object-mother has to be found to survive the instinct-driven episodes, which have now acquired the full force of fantasies of oral sadism and other results of fusion. Also, the environment-mother has a special function, which is to continue to be herself, to be empathic towards her infant, to be there to receive the spontaneous gesture, and to be pleased.

The fantasy that goes with full-blooded id-drives contains attack and destruction. It is not only that the baby imagines that he eats the object, but also that the baby wants to take possession of the contents of the object. If the object is not destroyed, it is because of its own survival capacity, not because of the baby's protection of the object. This is one side of the picture.

The other side of the picture has to do with the baby's relation to the environment-mother, and from this angle there may come so great a protection of the mother that the child becomes inhibited or turns away. Here is a positive element in the infant's experience of weaning and one reason why some infants wean themselves.

In favourable circumstances there builds up a technique for the solution of this complex form of ambivalence. The infant experiences anxiety, because if he consumes the mother he will lose her, but this anxiety becomes modified by the fact that the baby

has a contribution to make to the environment-mother. There is a growing confidence that there will be opportunity for contributing-in, for giving to the environment-mother, a confidence which makes the infant able to hold the anxiety. The anxiety held in this way becomes altered in quality and becomes a sense of guilt.

Instinct-drives lead to ruthless usage of objects, and then to a guilt-sense which is held, and is allayed by the contribution to the environment-mother that the infant can make in the course of a few hours. Also, the opportunity for giving and for making reparation that the environment-mother offers by her reliable presence, enables the baby to become more and more bold in the experiencing of id-drives; in other words, frees the baby's instinctual life. In this way, the guilt is not felt, but it lies dormant, or potential, and appears (as sadness or a depressed mood) only if opportunity for reparation fails to turn up.

When confidence in this benign cycle and in the expectation of opportunity is established, the sense of guilt in relation to the id-drives becomes further modified, and we then need a more positive term, such as 'concern'. The infant is now becoming able to be concerned, to take responsibility for his own instinctual impulses and the functions that belong to them. This provides one of the fundamental constructive elements of play and work. But in the developmental process, it was the opportunity to contribute that enabled concern to be within the child's capacity.

A feature that may be noted, especially in respect of the concept of anxiety that is 'held', is that integration *in time* has become added to the more static integration of the earlier stages. Time is kept going by the mother, and this is one aspect of her auxiliary ego-functioning; but the infant comes to have a personal time-sense, one that lasts at first only over a short span. This is the same as the infant's capacity to keep alive the imago of the mother in the inner world which also contains the fragmentary benign and persecutory elements that arise out of the instinctual experiences. The length of the time-span over which a child can keep the imago alive in inner psychic reality depends partly on maturational processes and partly on the state of the inner defence organization.

I have sketched some aspects of the origins of concern in the early stages in which the mother's continued presence has a specific value for the infant, that is, if the instinctual life is to have freedom of expression. But this balance has to be achieved over and over again. Take the obvious case of the management of adolescence, or the equally obvious case of the psychiatric

patient, for whom occupational therapy is often a start on the road towards a constructive relation to society. Or consider a doctor, and his needs. Deprive him of his work, and where is he? He needs his patients, and the opportunity to use his skills, as others do.

I shall not develop at length the theme of lack of development of concern, or of loss of this capacity for concern that has been almost, but not quite, established. Briefly, failure of the object-mother to survive or of the environment-mother to provide reliable opportunity for reparation leads to a loss of the capacity for concern, and to its replacement by crude anxieties and by crude defences, such as splitting, or disintegration. We often discuss separation-anxiety, but here I am trying to describe what happens between mothers and their babies and between parents and their children when there is *no* separation, and when external continuity of child-care is *not* broken. I am trying to account for things that happen when separation is avoided.

To illustrate my communication I shall give a few examples from clinical work. I do not want, however, to suggest that I am referring to anything rare. Almost any psycho-analysis would provide an example in the course of a week. And it must be remembered that in any clinical example taken from an analysis there is a host of mental mechanisms that the analyst needs to be able to understand which belong to later stages of the individual's development, and to the defences that are called psycho-neurotic. These can be ignored only when the patient is in a state of severe regression to dependence in the transference, and is, in effect, a baby in the care of a mother-figure.

Example I: First I cite the case of the boy of twelve whom I was asked to interview. He was a boy whose *forward* development led him to depression, which included a vast quantity of unconscious hate and aggression, and whose *backward* development, if I may use the phrase, led him to seeing faces, to experiences that were horrible because they represented dreams dreamed in the waking state, hallucinosis. There was good evidence of ego-strength in this boy, as witness his depressive moods. One way that this ego-strength showed in the interview was as follows:

He drew a nightmare, with a huge horned male-creature threatening a tiny self, an 'ant'-self. I asked if he had ever dreamed of himself as the huge horned male, with the ant as someone else, his brother, for instance, at the time of the brother's infancy. He allowed this. When he did not reject my interpretation of his hatred of his brother, I gave him an opportunity to tell me of his reparative potential. This came quite naturally through his description of his father's job as a

refrigeration mechanic. I asked him what he himself might want one day to be. He 'had no idea', and he was distressed. He then reported 'not a sad dream, but what a sad dream would be: his father dead'. He was near tears. In this phase of the interview there was a long period of nothing much happening. At length the boy said, very shyly, that he would like to be a scientist.

Here, then, he had shown that he could think of himself as contributing. Though he may not have had the requisite ability, he had the idea. Incidentally, this pursuit would bring him right ahead of his father because, as he said, his father's job was not at all that of a scientist, it was 'just being a mechanic'.

I then felt the interview could end in its own time; I felt the boy could go away without being disturbed by what I had done. I had interpreted his potential destructiveness, but it was true that he had it in him to be constructive. His letting me know he had an aim in life enabled him to go, without feeling he had made me think he was only a hater and a destroyer. And yet, I had not reassured him.

Example II: A patient of mine doing psychotherapy started off a session by telling me that he had been to see one of his patients performing; that is to say, he had gone outside the role of a therapist dealing with the patient in the consulting room, and had seen this patient at work. The work of my patient's patient was highly skilled, and he was very successful in a particular job in which he used quick movements which in the therapeutic hour made no sense, but moved him around on the couch as if he were possessed. Although doubtful about having seen this man at work, my patient felt that probably it was a good thing. He then referred to his own activities in the holidays. He had a garden, and he very much enjoyed physical labour and all kinds of constructive activity, and he liked gadgets, which he really used.

I had been alerted to the importance of his constructive activities by his report of his having gone to see his patient at work. My patient returned to a theme which had been important in the recent analysis in which various kinds of engineering tools were important. On his way to the analytic session he often stopped and gazed at a machine tool in a shop window near my house. The tool had the most splendid teeth. This was my patient's way of getting at his oral aggression, the primitive love-impulse with all its ruthlessness and destructiveness. We could call it 'eating in the transference relationship'. The trend in his treatment was towards this ruthlessness and primitive loving, and the resistance against getting to the deep layers of it was

tremendous. Here was a new integration and a concern about the survival of the analyst.

When this new material came up relating to primitive love and to the destruction of the analyst, *there had already been* some reference to constructive work. When I made the interpretation that the patient needed from me, about his destruction of me (eating), I could have reminded him of what he had said about construction. I could have said that just as he saw his patient performing, and the performance made sense of the jerky movements, so I might have seen him working in his garden, using gadgets in order to improve the property. He could cut through walls and trees, and it was all enjoyed tremendously. If such activity had come apart from a report of the constructive aim it would have been a senseless maniacal episode, a transference madness.

I would say that human beings cannot accept the destructive aim in their very early loving attempts. The idea of destruction of the object-mother in loving can be tolerated, however, if the individual who is getting towards it has evidence of a constructive aim already at hand, and of an environment-mother ready to accept.

Example III: A man patient came into my room and saw a tape-recorder. This gave him ideas, and he said as he lay down and as he gathered himself together for the work of the analytic hour, 'I would like to think that when I have finished treatment, what has happened here with me will be of value to the world in some way or other.' I said nothing, but I made a mental note that this remark *might* indicate that the patient was near to one of those bouts of destructiveness with which I had had to deal repeatedly in two years of his treatment. Before the end of the hour, the patient had truly reached a new awareness of his envy of me, an envy which was the outcome of his thinking I was a good analyst. He had the impulse to thank me for being good, and for being able to do what he needed me to do. We had had all this before, but he was now more than on previous occasions in touch with his destructive feelings towards what might be called a good object, his analyst.

When I linked these two things, he said that this felt right, but he added how awful it would have been if I had interpreted on the basis of his first remark. He meant, if I had taken up his wish to be of use and had told him that this indicated an unconscious wish to destroy. He had to reach to the destructive urge before I acknowledged the reparation, and he had to reach it in his own time and in his own way. No doubt it was his capacity to

have an idea of ultimately contributing that was making it possible for him to get into more intimate contact with his destructiveness. But constructive effort is false and meaningless unless, as he said, one has first reached to the destruction.

Example IV: An adolescent girl was having treatment from a therapist who was also taking care of the girl at the same time in the therapist's home, along with her own children. This arrangement had advantages and disadvantages.

The girl had been severely ill, and at the time of the incident I shall recount she was emerging from a long period of regression to dependence and to an infantile state. She is no longer regressed in her relation to the home and the family, but is still in a very special state in the limited area of the treatment sessions which occur at a set time each day.

A time came when the girl expressed the deepest hate of the therapist (who is both caring for her and doing her treatment). All was well in the rest of the twenty-four hours, but in the treatment area the therapist was destroyed utterly, and repeatedly. It is difficult to convey the degree of the girl's hate of the therapist and, in fact, the annihilation of her. Here it was not a case of the therapist going out to see the patient at work, for the therapist had charge of the girl all the time, and there were two separate relationships going on between them simultaneously. In the day, all sorts of new things began to happen: the girl began to want to help clean the house, to polish the furniture, to be of use. This helping was absolutely new, and had never been a feature in this girl's personal pattern in her own home, even before she became acutely ill. And it happened silently (so to speak) alongside the utter destructiveness that the girl began to find in the primitive aspects of her loving, which she reached in her relation to the therapist in the therapy sessions.

You see the same idea repeating itself here. Naturally, the fact that the patient was becoming conscious of the destructiveness, made possible the constructive activity which appeared in the day. *But it is the other way round that I want to make plain here and now.* The constructive and creative experiences were making it possible for the child to get to the experience of her destructiveness. And thus, in the treatment, conditions were present that I have tried to describe. The capacity for concern is not only a maturational node, but it also depends for its existence on an emotional environment that has been good enough over a period of time.

Summary

Concern, as the term has been used here, describes the link between the destructive elements in drive-relationships to object, and the other positive aspects of relating. Concern is presumed to belong to a period prior to the classical Oedipus complex, which is a relationship between three whole persons. The capacity for concern belongs to the two-body relationship between the infant and the mother or mother-substitute.

In favourable circumstances, the mother by continuing to be alive and available is both the mother who receives all the fullness of the baby's id-drives, and also the mother who can be loved as a person and to whom reparation can be made. In this way, the anxiety about the id-drives and the fantasy of these drives becomes tolerable to the baby, who can then experience guilt, or can hold it in full expectation of an opportunity to make reparation for it. To this guilt that is held but not felt as such, we give the name 'concern'. In the initial stages of development, if there is no reliable mother-figure to receive the reparation-gesture, the guilt becomes intolerable, and concern cannot be felt. Failure of reparation leads to a losing of the capacity for concern, and to its replacement by primitive forms of guilt and anxiety.

7

FROM DEPENDENCE TOWARDS INDEPENDENCE IN THE DEVELOPMENT OF THE INDIVIDUAL[1]

(1963)

I have chosen in this chapter to describe emotional growth in terms of the journey from dependence to independence. If you had asked me to perform this task thirty years ago I should almost certainly have referred to the changes by which immaturity gives place to maturity in terms of progression in the individual's instinctual life. I would have referred to the oral phase, and to the anal phase, and to the phallic phase and the genital. I might have divided these phases up—first oral, preambivalent, second oral, oral sadistic, and so on. Some authors have very much divided up the anal phase; others have been content to have the idea of a pregenital phase that is based generally on the functioning of the organs of ingestion, absorption, and elimination. All this is good. It is as true now as it was, and it has started off our thinking and the structure of the theory by which we steer our course. Nevertheless, it is now in our bones, so to speak. We take it for granted, and we look to other aspects of growth when we find ourselves in the position I am in just now, where I am expected to say something that is not exactly common knowledge, or that takes into consideration the later developments in theory and attitude.

If I have chosen to look at growth in terms of dependence changing gradually towards independence you will agree, I hope, that this does not in any way invalidate the statement I might have made of growth in terms of erotogenic zones, or of object relating.

Socialization

Maturity of the human being is a term that implies not only personal growth but also socialization. Let us say that in health, which is almost synonymous with maturity, the adult is able to identify with society without too great a sacrifice of personal spontaneity; or, the other way round, the adult is able to attend

[1] Talk given at the Atlanta Psychiatric Clinic, October 1963.

to his or her own personal needs without being antisocial, and indeed, without a failure to take some responsibility for the maintenance or for the modification of society as it is found. We get left with certain social conditions, and this is a legacy we have to accept, and, if necessary, alter; it is this that we eventually hand down to those who come after us.

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.

The Journey

There is nothing new about the idea of a journey from dependence to independence. Each human being must start on this journey, and many arrive somewhere not far from this destination, and arrive at independence with a built-in social sense. Here psychiatry is looking at healthy growth, a matter which is often left to the educationalist or to the psychologist.

The value of this approach is that it enables us to study and discuss at one and the same time the personal and the environmental factors. In this language health means both health of the individual and health of society, and full maturity of the individual is not possible in an immature or ill social setting.

Three Categories

In planning this brief statement on a very complex theme I find I need three rather than two categories, not simply dependence and independence. It is helpful to think separately of:

absolute dependence;
relative dependence;
and towards independence.

Absolute Dependence

I will first draw your attention to the very early stages of the emotional development of every infant. At the beginning the infant is entirely dependent on the physical provision of the live mother and her womb or her infant care. But in terms of psychology we have to say that the infant is at one and the same time dependent and independent. It is this paradox that we need to examine. There is all that is inherited, including the maturational processes, and perhaps pathological inherited trends, and these have a reality of their own, and no one can alter these; at the same time, the maturational processes depend for their

evolution on the environmental provision. We can say that the facilitating environment makes possible the steady progress of the maturational processes. But the environment does not make the child. At best it enables the child to realize potential.

This term 'maturational process' refers to the evolution of the ego and of the self, and includes the whole story of the id, of instincts and their vicissitudes, and of defences in the ego relative to instinct.

In other words, a mother and father do not produce a baby as an artist produces a picture or a potter a pot. They have started up a developmental process which results in there being a lodger in the mother's body and then in her arms and then in the home provided by the parents, and what this lodger will turn out to be like is outside anyone's control. The parents are dependent on the infant's inherited tendencies. It may well be asked: 'What then can they do if they cannot make their own child?' They can of course do a great deal. I shall say that they can provide for a child who is healthy, in the sense of being mature according to what maturity means at any moment for that child. If they succeed in making this provision then the infant's maturational processes are not blocked but are met and enabled to become part of the child.

It turns out that this adapting to the infant's maturational processes is a highly complex thing, one that makes tremendous demands on the parents, and at first it is the mother herself who is the facilitating environment. She needs support at this time, which is best given by the child's father (let us say her husband), her mother, the family and the immediate social environment. This is terribly obvious but none the less true and needing to be said.

I like to give this special state of the mother a special name, because I think its importance is not appreciated. Mothers recover from this state and forget. I call it 'primary maternal preoccupation'. This is not necessarily a good name, but the point is that towards the end of the pregnancy and for a few weeks after the birth of a child the mother is preoccupied with (or better, 'given over to') the care of her baby, which at first seems like a part of herself; moreover she is very much identified with the baby and knows quite well what the baby is feeling like. For this she uses her own experiences as a baby. In this way the mother is herself in a dependent state, and vulnerable. It is to describe this stage that I use the words *absolute dependence* in referring to the state of the baby.

In this way natural provision is made in nature for what the

infant needs, which is a high degree of *adaptation*. I will explain what I mean by this word.

In early psycho-analytic days adaptation could only mean one thing, meeting the infant's instinctual needs. A great deal of misconception has arisen out of the slowness of some to understand that an infant's needs are not confined to instinct tensions, important though these may be. There is the whole of the infant's ego development that has its own needs. The language here is that the mother 'does not let her infant down', though she may and must frustrate in the sense of meeting instinct needs. It is amazing how well mothers do meet the ego-needs of their own infants, even mothers who are not good at giving the breast but who quickly substitute the bottle and the formula.

There are always a few who cannot fully commit themselves in the way that is needed at this very early stage, although the stage only lasts a few months towards the end of pregnancy and at the beginning of the infant's life.

I shall describe ego-needs, since these are multifarious. The best example would be the simple matter of holding. No one can hold a baby unless able to identify with the baby. Balint (1951, 1958) has referred to the oxygen in the air, of which the infant knows nothing. I could remind you of the temperature of the bathwater, tested by the mother's elbow; the infant does not know that the water might have been too hot or too cold, but comes to take for granted the body temperature. I am still talking about absolute dependence. It is all a matter of impingement, or no impingement, on the infant's existence, and I want to develop this theme.

All the processes of a live infant constitute a *going-on-being*, a kind of blue-print for existentialism. The mother who is able to give herself over, for a limited spell, to this her natural task, is able to protect her infant's going-on-being. Any impingement, or failure of adaptation, causes a reaction in the infant, and the reaction breaks up the going-on-being. If reacting to impingements is the pattern of an infant's life, then there is a serious interference with the natural tendency that exists in the infant to become an integrated unit, able to continue to have a self with a past, present, and future. With a relative absence of reactions to impingements the infant's body-functions give a good basis for the building up of a body-ego. In this way the keel is laid down for future mental health.

You see how it is that the sensitive adaptation to an infant's ego-needs only lasts a little while. Soon the infant begins to get a kick out of kicking, and to get something positive out of being

angry because of what could be called minor failures of adaptation. But by this time the mother is beginning to restart her own life that eventually becomes relatively independent of her infant's needs. Often the child's growing up corresponds quite accurately with the mother's resumption of her own independence, and you would agree that a mother who cannot gradually *fail* in this matter of sensitive adaptation is failing in another sense; she is failing (because of her own immaturity or her own anxieties) to give her infant reasons for anger. An infant that has no reason for anger, but who of course has in him (or her) the usual amount of whatever are the ingredients of aggressiveness, is in a special difficulty, a difficulty in fusing aggression in with loving.

So in absolute dependence the infant has no means of awareness of maternal provision.

Relative Dependence

Just as I call the first stage 'absolute dependence', so I call the next stage 'relative dependence'. In this way one can distinguish between dependence that is quite beyond the infant's ken, and dependence that the infant can know about. A mother does a vast amount in meeting her infant's ego-needs, all of which goes unrecorded in the infant mind.

The next stage, that of relative dependence, turns out to be a stage of adaptation with a gradual failing of adaptation. It is part of the equipment of the great majority of mothers to provide a graduated de-adaptation, and this is nicely geared to the rapid developments that the infant displays. For instance, there is the beginning of intellectual understanding, which develops as a vast extension of simple processes, such as conditioned reflexes. (Think of an infant expecting a feed. The time comes when the infant can wait a few minutes because noises in the kitchen indicate that food is about to appear. Instead of simply being excited by the noises, the infant uses the news item in order to be able to wait.)

Naturally infants vary very much in their capacity to use intellectual understanding early, and often the understanding they might have had is delayed by the existence of a muddle in the way reality is presented. There is an idea for emphasis here, for the whole procedure of infant-care has as its main characteristic a steady presentation of the world to the infant. This is something that cannot be done by thought, nor can it be managed mechanically. It can only be done by continuous management by a human being who is consistently herself. There is no question of perfection here. Perfection belongs to machines; what the

infant needs is just what he usually gets, the care and attention of someone who is going on being herself. This of course applies to fathers too.

A special point needs to be made of this 'being herself' because one should separate out the person from the man or woman, mother or nurse, who is *acting* the part, perhaps acting it quite well at times, and perhaps acting it well because of having learned how to care for infants from books or in a class. But this acting is not good enough. The infant can only find an unmuddled presentation of external reality by being cared for by a human being who is devoted to the infant and to the infant-care task. The mother will grow up out of this state of easy devotion, and soon she will be back to the office desk, or to writing novels, or to a social life along with her husband, but for the time being she is in it up to the neck.

The reward at the first stage (absolute dependence) is that the infant's process of development is not distorted. The reward at this stage of relative dependence is that the infant begins to be in some way *aware of dependence.* When the mother is away for a moment beyond the time-span of his (or her) capacity to believe in her survival, anxiety appears, and this is the first sign that the infant knows. Before this, if the mother is away the infant simply fails to benefit from her special ability to ward off impingements, and essential developments in ego structure fail to become well established.

The next stage beyond that at which the infant in some way feels a need for the mother is one in which the infant begins to *know in his mind* that mother is necessary.

Gradually the need for the actual mother (in health) becomes fierce and truly terrible, so that mothers do really hate to leave their children, and they sacrifice a great deal rather than cause distress and indeed produce hatred and disillusionment during this phase of special need. This phase could be said to last from (roughly) six months to two years.

By the time an infant is two years old there have begun new developments, and these equip the child to deal with loss. It will be necessary to refer to these. Along with these personality developments in the child there are important though variable environmental factors to be taken into consideration. For instance there may be the mother-nurse team, itself an interesting subject for study. There may be suitable aunts and grandparents or special friends of the parents who by their constant presence qualify as mother-substitutes. Then also the mother's husband may be an important person in the home, helping to create a

home, and he may be a good mother-substitute, or he may be important in a more masculine way by giving his wife support and a feeling of security, which she can pass on to the infant.

It will not be necessary to deal fully with these rather obvious and yet highly significant details. It will be seen, however, that these details vary greatly, and the infant's own growth-processes are pulled this way and that according to what obtains.

Case Material:

I had the chance to observe a family of three boys at the time of their mother's sudden death. The father acted in a responsible way, and the mother's friend who knew the boys well took over their care, and after a period of time she became their stepmother.

The baby boy was four months old when his mother suddenly disappeared from his life. His development proceeded satisfactorily and there was no clinical sign indicating a reaction. In my language the mother was 'a subjective object' for this baby boy, and the mother's friend stepped into the mother's position. Later he thought of his stepmother as his mother.

When this the youngest boy was four years he was brought to me, however, because he was starting to show various personality difficulties. In play in the psychotherapeutic interview he invented a game which had to be repeated very many times. He hid, and I made a very slight alteration in, say, the position of a pencil on the table. He then came in, found the slight alteration, and became very angry indeed and killed me. He would have persisted with this game for hours.

Applying what I had learned I told his stepmother to be ready to talk to him about death. That very evening, for the first time in his life, he gave the stepmother a chance to talk about death, and this led on to his needing to know exactly all the facts about the mother whose inside he came out of, and of her death. This then gathered momentum in the next few days, and everything had to be repeated and repeated. He continued with his good relationship with his stepmother whom he continued to call mother.

The oldest of the three children was six years old when his mother died. He simply mourned her as a person who was loved. The mourning process took about two years, and as he emerged from it he had a bout of stealing. He accepted the stepmother as a stepmother, and he remembered his real mother as a person sadly lost.

The middle boy was three at the time of the tragedy. He was

strongly in a positive relationship with his father at the time, and he became a psychiatric casualty, needing psychotherapy (about seven sessions over a period of eight years). The oldest boy said of this one: 'We didn't tell him of father's remarriage because he thinks marriage means "killing".'

This middle boy was in a muddle, and unable to cope with the guilt that he needed to be able to experience because of his mother's dying when he was in the homosexual phase with special attachment to his father. He said: 'I don't mind, it was —— (the older brother) who loved her.' Clinically he became hypomanic. His extreme restlessness lasted a long time, and it was clear that a depression was threatening. His play showed a degree of muddle, but he was able to organize his play sufficiently to convey to me in the psychotherapeutic sessions what were the specific anxieties that made him restless.

There are still signs of residual psychiatric disorder in this boy who is now thirteen—that is, ten years after the tragedy which for this one boy proved traumatic.

One important development in the infant comes under the heading 'identification'. Quite early an infant may be able to show a capacity to identify with the mother. There are primitive reflexes that may be said to form a basis for these developments, as when a baby responds to a smile with a smile. Quickly the baby becomes capable of more complex forms of identification, implying the existence of an imagination. An example of this would be the infant who may wish to find the mother's mouth and feed her with his or her finger while taking the breast. I have seen this happen at three months; but dates should not worry us. Sooner or later these things happen to all infants (except to some ill infants) and we know that a great relief from dependence follows the development in an infant of a capacity to step into the mother's shoes. Out of this comes the full development of an understanding of the mother's personal and separate existence, and *eventually* the child comes to be able to believe in the parents' coming together which in fact led to his or her own conception. This is a long way ahead and never achieved at deepest levels.

The effect of these new mental mechanisms on the subject of dependence is that the infant can allow for events that are outside his or her control, and because of being able to identify with the mother or the parents the infant can side-track some of the very great hatred that is felt towards that which challenges the infant's omnipotence.

Then speech becomes understood and perhaps used. This

tremendous development in the human animal enables the parents to give every opportunity for the infant to co-operate, through intellectual understanding, even though *in deep feelings* the infant may feel grief, hatred, disillusionment, fear and impotence. The mother can say: 'I am going out to get some bread.' This may work unless, of course, she is away beyond the time-span of the infant's capacity to keep the idea of her alive, in feeling.

I wish to mention a form of development that especially affects the infant's capacity for making complex identifications. This has to do with the stage at which the integrating tendencies of the infant bring about a state in which the infant is a unit, a whole person, with an inside and an outside, and a person living in the body, and more or less bounded by the skin. Once outside means 'not-ME' then inside means ME, and there is now a place in which to store things. In the child's fantasy the personal psychic reality is located inside. If it is located outside there are good reasons.

Now the infant's growth takes the form of a continuous interchange between inner and outer reality, each being enriched by the other.

The child is now not only a potential creator of the world, but also the child becomes able to populate the world with samples of his or her own inner life. So gradually the child is able to 'cover' almost any external event, and perception is almost synonymous with creation. Here again is a means by which the child gains control over external events as well as over the inner workings of his or her own self.

Towards Independence

Once these things are established, as they are in health, the child is able gradually to meet the world and all its complexities, because of seeing there more and more of what is already present in his or her own self. In ever-widening circles of social life the child is identified with society, because local society is a sample of the self's personal world as well as being a sample of truly external phenomena.

In this way a true independence develops, with the child able to live a personal existence that is satisfactory, while involved in society's affairs. Naturally there are big possibilities for setback in this development of socialization, right up to the late stages beyond puberty and adolescence. Even a healthy individual may meet a social tension which is beyond what that individual could allow for, in advance of the individual's personal broadening of the basis of tolerance.

In practice you can watch your adolescents graduating from one grouping to another, all the time widening the circle, all the time embracing new and more and more strange phenomena that society throws up. Parents are very much needed in the management of their own adolescent children who are exploring one social circle after another, because of their ability to see better than their children can when this progression from the limited social circle towards the unlimited social circle is too rapid, perhaps because of dangerous social elements in the immediate neighbourhood, or because of the defiance that belongs to puberty and to a rapid development in the sexual capacity. They are needed especially because of the instinct tensions and patterns that reappear and which were first laid down at the toddler age.

'Towards independence' describes the strivings of the toddler child and of the child at puberty. In the latency period children are usually contented with whatever dependence that they are lucky to be able to experience. Latency is the period of school playing a role as a substitute for home. This is not always true, but there is no place for a further development of this special theme here.

Adults must be expected to be continuing the process of growing and of growing up, since they do but seldom reach to full maturity. But once they have found a niche in society through work, and have perhaps married or have settled in some pattern that is a compromise between copying the parents and defiantly establishing a personal identity, once these developments have taken place, adult life can be said to have started, and the individuals one by one climb out of the area covered by this brief statement of growth in terms of dependence towards independence.

8

MORALS AND EDUCATION[1]

(1963)

The title of my lecture gives me scope to develop the theme not so much of society that changes as of human nature that does not change. Human nature does not change. This is an idea that could be challenged. Nevertheless, I shall assume its truth, and build on this foundation. It is true that human nature evolved, just as human bodies and beings evolved, in the course of hundreds of thousands of years. But there is very little evidence that human nature has altered in the short span of recorded history; and comparable with this is the fact that what is true about human nature in London today is also true in Tokyo, in Accra, in Amsterdam and Timbuktoo. It is true for whites and blacks, for giants and pygmies, for the children of the Harwell or Cape Canaveral scientist and for the children of the Australian aboriginal.

Applied to the subject that is under discussion (moral education today) this means that there is an area for study that may be called the capacity of the human child to be morally educated. What I am referring to in this lecture is limited to this area, the human child's development of a capacity for having a moral sense, for experiencing a sense of guilt and for the setting up of an ideal. Analogous would be an attempt to get behind such an idea as 'belief in God' to the idea of 'belief', or (as I would prefer to say) 'belief in'. To a child who develops 'belief in' can be handed the god of the household or of the society that happens to be his. But to a child with no 'belief in', god is at best a pedagogue's gimmick, and at worst a piece of evidence for the child that the parent-figures are lacking in confidence in the processes of human nature and are frightened of the unknown.

Professor Niblett in the opening lecture of this series referred to the headmaster Keate who said to a child: 'You will believe in the Holy Ghost by 5 o'clock this afternoon or I will beat you till you do,' and in this way Professor Niblett led on to the idea of the futility of teaching values or religion by force. I am trying to

[1] Lecture given in a series at University of London Institute of Education, 1962, and first published (under the title 'The Young Child at Home and at School') in *Moral Education in a Changing Society*, ed. W. R. Niblett. (London: Faber, 1963.)

open up this important theme and to examine the alternatives. My main point is that there does exist a good alternative, and that this good alternative is not to be found in a more and more subtle teaching of religion. The good alternative has to do with the provision of those conditions for the infant and child that enable such things as trust and 'belief in', and ideas of right and wrong, to develop out of the working of the individual child's inner processes. This could be called the evolution of a personal superego.

Religions have made much of original sin, but have not all come round to the idea of original goodness, that which by being gathered together in the idea of God is at the same time separated off from the individuals who collectively create and re-create this God concept. The saying that man made God in his own image is usually treated as an amusing example of the perverse, but the truth in this saying could be made more evident by a restatement, such as: man continues to create and re-create God as a place to put that which is good in himself, and which he might spoil if he kept it in himself along with all the hate and destructiveness which is also to be found there.

Religion (or is it theology?) has stolen the good from the developing individual child, and has then set up an artificial scheme for injecting this that has been stolen back into the child, and has called it 'moral education'. Actually moral education does not work unless the infant or child has developed in himself or herself by natural developmental process the stuff that, when it is placed up in the sky, is given the name God. The moral educator depends for success on there being that development in the individual child that enables the child to accept this God of the moral educator as a projection of the goodness that is part of the child and of his actual experience of life.

We are reduced in practice, therefore, whatever our theological system, to a dependence in the case of each new child on the way the child is being or has been enabled to make the grade developmentally. Has the child been able to pass, so to speak, his or her entrance examination in moral sense, or to acquire this thing that I am calling *belief in*? I cling to this ugly, incomplete phrase, belief in. In order to complete that which has been started up, someone must let the child know what we in this family and in this bit of society at the present time happen to believe in. But this completing process is of secondary importance, because if 'belief in' has not been reached then the teaching of morals or religion is mere Keatean pedagogy, and is generally accepted as objectionable or ludicrous.

I feel dissatisfied with the idea that is often expressed by otherwise well-informed persons that Freud's mechanistic approach to psychology or his reliance on the theory of the evolution of men from animals interferes with the contribution psychoanalysis might make to religious thought. It might even turn out that religion could learn something from psycho-analysis, something that would save religious practice from losing its place in the civilization processes, and in the process of civilization. Theology, by denying to the developing individual the creating of whatever is bound up in the concept of God and of goodness and of moral values, depletes the individual of an important aspect of creativeness.

Surely Mrs Knight in the controversy of some years ago was not devaluing God by comparing God with Father Christmas; she was saying or trying to say that you can put some parts of a child into the witch of the fairy story, some of the child's belief and generosity can be handed out to Father Christmas, and all sorts of feelings and ideas of goodness that belong to the child and his or her inner and outer experiences can be put out there and labelled 'God'. In the same way, nastiness in the child can be called 'the devil and all his works'. The labelling socializes the otherwise personal phenomenon. Practising psycho-analysis for thirty years has made me feel that it is the ideas bound up with the organization of moral education that deplete the individual of individual creativeness.

There are reasons why the ideas of the moral educationalist die hard. An obvious one is that there do exist wicked people. In my language, this means that there are persons in all societies and in all ages who in their emotional development did not reach to a stage of believing in, nor did they reach a stage of innate morality involving the total personality. But moral education that is designed for these ill persons is unsuitable for the vast majority of persons who, in fact, are not ill in this respect. I shall refer to wicked people again later.

So far I have spoken as an amateur theologian, but I have been asked to speak as a professional child psychiatrist. To contribute usefully I must now be able to give a brief story of the emotional development of the human infant and child. You know of course that this is an extremely complex subject and a story that cannot be briefly told. There are many ways of approaching the subject of emotional growth and I shall attempt to use various methods.

The basis of child-development is the physical existence of the infant along with his or her inherited tendencies. These inherited

tendencies include the maturational drives to forward development. Let us say, an infant tends to use three words at one year and tends to walk by fourteen months or so, and tends to reach the same shape and height as one of the parents, and tends to be clever or stupid or moody or to have allergies. In more hidden ways there starts in the infant and continues in the child a tendency towards integration of the personality, the word integration tending to have a more and more complex meaning as time goes on and as the child gets older. Also the infant tends to live in his or her body and to build the self on a basis of bodily functioning to which belong imaginative elaborations that quickly become extremely complex and constitute the psychic reality specific to that infant. The infant becomes established as a unit, feels an I AM feeling, and bravely faces the world with which he or she is already becoming able to form relationships, affectionate relationships and (by contrast) a pattern of object-relationships based on the instinctual life. And so on. All this, and much much more, is true and always has been true of human infants. Here is human nature unfolding itself. BUT, and this but is a big one, maturational processes depend for their becoming actual in the child, and actual at the appropriate moments, on a good enough environmental provision.

This is the old argument of nature and nurture. I suggest that this problem is not incapable of statement. The parents do not have to make their baby as the artist has to make his picture or the potter his pot. The baby grows in his or her own way if the environment is good enough. Someone has referred to the good enough provision as 'the average expectable environment'. The fact is that throughout the centuries mothers, and parents, and parent-substitutes, have in fact usually provided exactly those conditions that the infant and small child do in fact need at the beginning, at the stage of their greatest dependence, and this continues even a little later when, as children, the infants are becoming somewhat separate from the environment and relatively independent. After this things tend to be not so good, but at the same time this fact matters less and less.

It will be noted that I am referring to an age at which verbal teaching does not apply. Neither Freud nor psycho-analysis was needed to tell mothers and parents how to provide these conditions. These conditions start with a high degree of adaptation on the part of the mother to the infant's needs, and gradually become a series of failures of adaptation; these failures are again a kind of adaptation because they are related to the growing need of the child for meeting reality and for achieving separation

and for the establishment of a personal identity. (Joy Adamson describes all this beautifully in terms of her upbringing of Elsa the lioness, and of the cubs who are now Forever Free.)

It seems that although most religions have tended to recognize the importance of family life it fell to psycho-analysis to point out to the mothers of babies and to the parents of the very young the value—no, the essential nature—of their tendency to provide for each infant that which each infant absolutely needs by way of nurture.

The mother (I do not exclude the father) adapts so well that it can only be said that she is closely identified with her baby, so that she knows what is needed at any one moment, and also in a general way. The infant, of course, is at this first and earliest stage in a state of mergence, not yet having separated out mother and 'not-me' objects from the 'me', so that what is adaptive or 'good' in the environment is building up in the infant's storehouse of experience as a self quality, indistinguishable at first (by the infant) from the infant's own healthy functioning.

At this early stage the infant does not register what is good or adaptive, but reacts to, and therefore knows about and registers each failure of reliability. Reacting to unreliability in the infant-care process constitutes a trauma, each reaction being an interruption of the infant's 'going-on-being' and a rupture of the infant's self.

To sum up this first stage of my simplified scheme for describing the developing human being: the infant and small child is usually cared for in a reliable way, and this being cared for well enough builds up in the infant to a belief in reliability; on to this a perception of the mother or father or grandmother or nurse can be added. To a child who has started life in this way the idea of goodness and of a reliable and personal parent or God can follow naturally.

The child who is not having good enough experiences in the early stages cannot be given the idea of a personal God *as a substitute for infant-care.* The vitally important subtle communicating of the infant-mother kind antedates the stage at which verbal communication can be added. This is a first principle of moral education, that *moral education is no substitute for love.* At the beginning love can only be expressed effectually in terms of infant- and child-care, which means for us the provision of a facilitating or good-enough environment, and which means for the infant a chance to evolve in a personal way according to the steady gradation of the maturational process.

How can I go on to develop this theme, taking into account the

rapidly increasing complexity of the individual child's inner reality and the expanding storehouse of the child's internal and external experiences remembered, or for economy forgotten?

At this point I must try to say something about the origin in the infant or small child of those elements which the words good and bad can describe and be apposite. It is not necessary of course that words should be offered at this stage, and indeed approval and disapproval can be conveyed to the deaf, and to infants at a stage long before verbal communication has begun. There do develop in the infant certain opposed feelings, apart altogether from the approval and disapproval which is conveyed to the child by the parent, and it is these that must be noted and perhaps tracked down to their source.

In the developing storehouse of personal memories and of the phenomena that constitute the inner psychic reality of the individual child there appear elements which are at first simply opposed. They may be called supportive and disruptive elements, or friendly and hostile elements, or benign and persecutory elements; these arise partly out of the infant's satisfactions and frustrations in the living experience, which includes excitements, and partly this build-up of positive and negative elements depends on the infant's capacity to avoid the pain of ambivalence by not joining up the objects that feel to be either good or bad.[1]

I cannot avoid using the words good and bad here even though to do so defeats my own object, which is to describe phenomena prior to the use of words. The fact is that these important things that are going on in the developing infant and small child demand description in terms of good and bad.

All this is closely intertwined with the perception of maternal approval and disapproval, but here as everywhere the internal and personal factor is more important than the external or environmental factor, a precept which is at the very heart of my communication. If I am wrong in this respect then my thesis is faulty. If my thesis is faulty, then infants and small children do depend on having right and wrong injected into them. This means that parents must approve and disapprove instead of loving, and in fact they must be moral educators instead of parents. How they would hate this!

The child does need to meet with approval and disapproval, but parents on the whole find themselves waiting, refraining from showing approval and disapproval until they have found in their infant the elements of a sense of values and of good and bad and

[1] This primitive state of affairs becomes employed as a defence against the pain of ambivalence and is then called 'splitting' the object.

of right and wrong, that is, in the particular area of child-care which is significant at the moment.

It is now necessary to take a glimpse at the inner psychic reality of the infant and child. This becomes a rapidly growing personal world that is localized by the child both inside and outside the self, the self that is but newly established as a unit with a 'skin'. What is inside is part of the self though not inherently so, and it can be projected. What is outside is not part of the self, but again not inherently so, and it can be introjected. In health, a constant interchange goes on as the child lives and collects experiences, so that the external world is enriched by the inner potential, and the inner is enriched by what belongs outside. The basis for these mental mechanisms is clearly the functioning of incorporation and elimination in bodily experience. Ultimately it may be perceived by the child, who is by then becoming a mature individual, that there does exist that which is truly environmental, and this (the environmental) includes the inherited tendencies as well as the environmental provision and the world past and future, and the universe as yet unknown.

It is evident that as the child grows in this way the content of his personal self is not only he. The self becomes increasingly shaped by the environmental provision. The baby who adopts an object as almost part of the self could not have adopted it unless it had been lying round for adoption. In the same way all the introjects are not only exports reimported, they are also truly foreign goods. The infant cannot know this until considerable maturation has taken place, and the mind has become able to deal intellectually and intelligently with phenomena that have no meaning in terms of emotional acceptance. In terms of emotional acceptance the self, at its core, is always personal, isolated and unaffected by experience.

This way of looking at emotional development is important for my argument, for as the infant grows in this way the stage becomes set for those engaged in infant- and child-care to leave lying round not only objects (such as golliwogs or teddy bears or dolls or toy engines) but also moral codes. These moral codes are given in subtle ways by expressions of acceptance or by threats of the withdrawal of love. In fact, the phrase 'sphincter morality' has been used to describe the way that ideas of right and wrong can be conveyed to infants and small children in terms of the way in which incontinence turns into socialized self-control. Control over excretions is only one rather obvious instance in a host of comparable phenomena. However, in terms of sphincter morality, it is easy to see that parents who expect the small child

to comply with the regulations before reaching the stage in which self-control has meaning are depriving the child of the sense of achievement and of faith in human nature that comes from a natural progress towards sphincter control. This sort of mistaken attitude to 'training' ignores the child's maturational processes, and ignores the child's wanting to be like the other persons and animals who are in the child's world.

No doubt there are and always will be those who by nature and nurture prefer to implant morals, just as there are also those who by nature and nurture prefer to wait, and perhaps to wait a long time, for natural developments. Nevertheless such matters can be discussed.

In these matters the answer is always that there is *more to be gained from love than from education.* Love here means the totality of infant- and child-care, that which facilitates maturational processes. It includes hate. Education means sanctions and the implantation of parental or social values *apart from* the child's inner growth or maturation. Education in terms of the teaching of arithmetic has to wait for that degree of personal integration in the infant that makes the concept of *one* meaningful, and also the idea contained in the first pronoun singular. The child who knows the I AM feeling, and who can carry it, knows about one, and then immediately wants to be taught addition, subtraction and multiplication. In the same way moral education follows naturally on the arrival of morality in the child by the natural developmental processes that good care facilitates.

Sense of Values

Soon the question arises: what about a sense of values generally? What is the parents' duty here? This more general issue follows on the management of the more specific issues of infant behaviour. Again there are those who fear to wait, and who implant, just as there are those who wait, and keep ready for presentation the ideas and expectations that the child can use on his arrival at each new developmental stage of integration and capacity for objective consideration.

In regard to religion, and the idea of a god, there are clearly the extremes of those who do not know that the child has a capacity to create a god so that they implant the idea as soon as possible, and there are those who wait and see the results of their efforts to meet the needs of their developing infant. These latter, as I have already said, will introduce the family gods to the child when the child has reached to the stage for their acceptance. In

the latter case, there is the minimum of set pattern; in the first case the set pattern is what is wanted, and the child can only accept or reject this essentially foreign thing, the implanted god concept.

Advocates could be found for not leaving any cultural phenomena lying round for the child to catch hold of and to adopt. I even knew a father who refused to allow his daughter to meet any fairy story, or any idea such as that of a witch or a fairy, or of a prince, because he wanted his child to have only a personal personality; the poor child was being asked to start again with the building up of the ideas and the artistic achievements of the centuries. This scheme did not work.

In the same way it is no answer to the problem of moral values to expect a child to have his or her own, and for the parents to have nothing to offer that comes from the local social system. And there is a special reason why a moral code should be available, namely, that the infant's and the small child's innate moral code has a quality so fierce, so crude, and so crippling. Your adult moral code is necessary because it humanizes what for the child is subhuman. The infant suffers talion fears. The child bites in an excited experience of relating to a good object, and the object is felt to be a biting object. The child enjoys an excretory orgy and the world fills with water that drowns and with filth that buries. These crude fears become humanized chiefly through each child's experiences in relation to the parents, who disapprove and are angry but who do not bite and drown and burn the child in retaliation related exactly to the child's impulse or fantasy.

By experience of life and living the child in health becomes ready to believe in something that can be handed over in terms of a personal god. But the personal god idea has no value to a child who has not had the experience of human beings, persons humanizing the terrifying superego formations that relate directly to the infantile impulse and to the fantasy that goes with body functioning and with crude excitements involving instinct.[1]

This principle affecting the handing on of moral values applies likewise to the handing on of the whole torch of culture and civilization. Give a child Mozart and Haydn and Scarlatti from the beginning and you may get precocious good taste, something that can be shown off at parties. But the child probably has to start with noises blown through toilet paper over a comb, and then to graduate to drumming on a saucepan and blowing into

[1] Erikson has written on this theme in terms of the concept of virtue (Erikson, 1961).

an old bugle; the distance from screaming and from vulgar noises to *Voi che Sapete* is vast, and an appreciation of the sublime should be a personal achievement, not an implant. Yet no child can write or perform his or her own Mozart. You must help him to find this and other treasures. In the area of living this implies that you provide your child with an example, not better than you really are, not dishonest, but tolerably decent.

The fiercest morality is that of early infancy, and this persists as a streak in human nature that can be discerned throughout an individual's life. Immorality for the infant is *to comply at the expense of the personal way of life.* For instance, a child of any age may feel that to eat is wrong, even to the extent of dying for the principle. Compliance brings immediate rewards and adults only too easily mistake compliance for growth. The maturational processes can be by-passed by a series of identifications, so that what shows clinically is a false, acting self, a copy of someone perhaps; and what could be called a true or essential self becomes hidden, and becomes deprived of living experience. This leads many people who seem to be doing well eventually to end their lives which have become false and unreal; unreal success is morality at its lowest ebb as compared with which a sexual misdemeanour hardly counts.

One stage in the child's development has especial importance, and I must refer to it, although it is only a new and much more complex example of the environmental provision facilitating maturational processes.

At this stage to which I refer now there is a gradual build-up in the child of a capacity to feel a sense of responsibility, that which at base is a sense of guilt. The environmental essential here is the continued presence of the mother or mother-figure over the time in which the infant and child is accommodating the destructiveness that is part of his make-up. This destructiveness becomes more and more a feature in the experience of object relationships, and the phase of development to which I am referring lasts from about six months to two years, after which the child may have made a satisfactory integration of the idea of destroying the object and the fact of loving the same object. The mother is needed over this time and she is needed because of her survival value. She is an environment-mother and at the same time an object-mother, the object of excited loving. In this latter role she is repeatedly destroyed or damaged. The child gradually comes to integrate these two aspects of the mother and to be able to love and to be affectionate with the surviving mother at the same time. This phase involves the child in a special kind of anxiety

which is called a sense of guilt, guilt related to the idea of destruction where love is also operating. It is this anxiety that drives the child towards constructive or actively loving behaviour in his limited world, reviving the object, making the loved object better again, rebuilding the damaged thing. If the mother-figure is not able to see the child through over this phase then the child fails to find or loses the capacity to feel guilt, but instead feels crudely anxious and this anxiety is merely wasteful. (I have described this elsewhere and more thoroughly than I can do it here, and of course the chief work leading to this part of our understanding of the child's development comes from Melanie Klein, and is to be found in her writings under the heading 'The Depressive Position'.)

Provision of Opportunity

Here is an essential stage in child-development, and it has nothing to do with moral education except that if this stage is successfully negotiated then the child's own and personal solution to the problem of destruction of what is loved turns into the child's urge to work or to acquire skills. It is here that the provision of opportunity, and this includes the teaching of skills, meets the child's need. But the need is the essential factor, and the need arises out of the child's establishment within the self of a capacity to stand feeling guilt in regard to destructive impulses and ideas, to stand feeling generally responsible for destructive ideas, because of having become confident in regard to reparative impulses and opportunities for contributing in. This reappears in a big way at the period of adolescence, and it is well known that the provision of opportunity for service for young people is of more value than moral education in the sense of teaching morals.

Earlier I indicated that I would return to the idea of wickedness and the wicked. For the psychiatrist the wicked are ill. Wickedness belongs to the clinical picture produced by the antisocial tendency. It ranges from bed-wetting to stealing and telling lies and includes aggressive behaviour, destructive acts and compulsive cruelty, and perversions. For an understanding of the oetiology of the antisocial tendency there exists a vast literature, and only a short statement can be allowed here. Briefly the antisocial tendency represents the hopefulness in a deprived child who is otherwise hopeless, hapless and harmless; a manifestation of the antisocial tendency in a child means that there has developed in the child some hopefulness, hope that a way may be

found across a gap. This gap is a break in the continuity of environmental provision, experienced at a stage of relative dependence. In every case there has been experienced a break in the continuity of the environmental provision, and one that resulted in a hold-up of maturational processes and a painful confusional clinical state in the child.

Often the child psychiatrist is able, in a case seen before the development of secondary gain, to help the child back over the gap, so that instead of stealing there appears a return of an old good relationship with mother or a mother-figure or parent. The wickedness goes if the gap is bridged. This is an over-simplification but it must suffice. Compulsive wickedness is about the last thing to be cured or even stopped by moral education. The child knows in his bones that it is *hope* that is locked up in the wicked behaviour, and that *despair* is linked with compliance and false socialization. For the antisocial or wicked person the moral educator is on the wrong side.

The understanding that psycho-analysis can offer has importance although its application-value is limited. Modern thinking, largely based on psycho-analysis, makes it possible to see what is important in infant- and child-care, and relieves the parents of the burden that they feel when they think they have to make their children good. It evaluates the maturational processes in individual growth, and relates these to the facilitating environment. It examines the development of moral sense in the individual, and demonstrates the way in which a capacity for feeling a sense of personal responsibility belongs to health.

What the psycho-analyst leaves unsolved has to do with the moral education of individuals in so far as they have not matured in essential respects, and in so far as they have no capacity for moral evaluation or for feeling responsibility. The psycho-analyst simply says that these people are ill, and in some cases he is able to give treatment that is effective. But there remains the moral educator's effort to deal with these individuals, whether they are ill or not. Here the psycho-analyst can only ask that the educator shall not spill over his methods designed for these ill persons so that they affect the well persons. The vast majority of people are not ill, though indeed they may show all manner of symptoms. Strong or repressive measures, or indoctrination even, may suit society's need in the management of the antisocial individual, but these measures are the worst possible thing for healthy persons, for those who can grow from within, given the facilitating environment especially in the early stages of growth. It is these latter, the healthy, who grow into the adults who

constitute society, and who collectively establish and maintain the moral code for the next decades, till their children take over from them.

As Professor Niblett said again in the first lecture of the series, we cannot meet out adolescents with the words: over to you. We have to provide them in infancy and childhood and adolescence, in home and in school, with the facilitating environment in which each individual may grow his or her own moral capacity, develop a superego that evolved naturally from crude superego elements of infancy, and find his or her own way of using or not using the moral code and general cultural endowment of our age.

By the time the child is growing up towards an adult state the accent is no longer on the moral code that we hand on; the accent has passed over to that more positive thing, the storehouse of man's cultural achievement. And, instead of moral education we introduce to the child the opportunity for being creative that the practice of the arts and the practice of living offers to all those who do not copy and comply but who genuinely grow to a way of personal self-expression.

Part Two

THEORY AND TECHNIQUE

9

ON THE CONTRIBUTION OF DIRECT CHILD OBSERVATION TO PSYCHO-ANALYSIS[1]

(1957)

I wish to deal with the confusion that I think may arise through an acceptance of the word 'deep' as synonymous with the word 'early'. I have published two contributions specifically in the field of direct observation; these concern (*a*) the infant's way of coming to terms with an object (Winnicott, 1941), and (*b*) the use of objects and phenomena during the time of the infant's transition from a purely subjective life to the next stage (Winnicott, 1951).

Each of these will provide useful material for the examination of my main thesis, which is that 'deep' in the analytic sense is not the same as 'early' in the sense of infant development.

The Observation of Infants in a Set Situation

(I will call this Action Research, to give it modern dress and to link it with Kris.)

It is possible to see three main stages in the approach of an infant to an object (one presented in a formal way, as described).

First Stage Initial reflex grasp;
withdrawal;
tension covering renewed voluntary grasp and slow passage of object to mouth.

Here the mouth becomes suffused, saliva flows.

Second Stage Mouthing of the object;
carefree use of the object in experimental exploration, in play and as something with which to feed others.

Here the object drops by mistake. Let us assume that it is picked up and returned to the infant.

Third Stage Riddance.

In considering these matters with reference to an example one

[1] Read at the 20th International Psycho-Analytical Congress, Paris, July 1957, and first published (in French) in the *Revue française de Psychanalyse*, **22**, pp. 205–11.

immediately needs to be given the age of the infant. Typical is eleven months. At thirteen and fourteen months infants have developed so many other interests that the main issue is likely to be obscured.

At ten months or nine months most infants will pass through the phases normally, though the younger they are the more they need some measure of that subtle co-operation which sensitive mothers can give, which supports yet does not dominate. It is not common in my experience for a six-months-old baby to show clearly the whole physical performance. Immaturity at that age is such that it is an achievement that the object has been grasped and held, and perhaps mouthed. Direct observation shows that the baby must have a physical and psychological maturity of a certain degree before being able to enjoy the full emotional experience.

When these phenomena appear in psycho-analysis, whether in a session or in a phase lasting days or weeks, it is not possible for the analyst to date what is observed or deduced. For the analyst who reviews the material presented in analysis it may seem as if the phenomena I have described were applicable to the patient's early infancy, even to the first weeks and days. This material may appear in the analysis mixed up with details that do actually belong to earliest infancy, even to the post-birth state. This the analyst must learn to allow for. Nevertheless it is in analysis that the full significance of the infant's play becomes recognized, play which indicates the whole of the fantasy of incorporation and elimination, and of the growth of the personality through imaginative eating.

Transitional Objects and Phenomena

In the simplest case, a normal baby adopts a piece of cloth or a napkin and becomes addicted to it, and the date is perhaps six months to a year or later. Examination of this phenomenon in analytic work makes it possible for us to refer to the capacity for symbol formation in terms of the use of a transitional object. In analytic work, however, it would seem possible to allow these ideas to apply in earliest infancy, in rudimentary form. Yet the fact remains that there is an age before which the transitional object cannot exist, on account of the immaturity of the infant. Also, animals have transitional objects. Even the thumb-sucking of earliest infancy cannot have the significance for the infant at birth that it can have for the infant of a few months, and certainly not the whole of the significance that compulsive thumb-sucking has for a psychotic child of ten years.

Deep is not synonymous with early, because an infant needs a degree of maturity before becoming gradually able to be deep. This is obvious, almost trite, yet I think it has not been given sufficient attention.

At this point it would be helpful if I could define the word 'deep'. James Strachey (1934), faced with this same problem, wrote:

> The ambiguity of the term, ('deep' interpretation) however, need not bother us. It describes, no doubt, the interpretation of material which is either genetically early and historically distant from the patient's actual experience or which is under an especially heavy weight of repression—material, in any case, which is in the normal course of things exceedingly inaccessible to his ego and remote from it.

He seems to accept the words as synonymous.

On looking into the matter we see that 'deep' is a matter of variable usage and 'early' is a matter of fact; which makes a comparison of the two difficult and of temporary significance. It is deeper to refer to infant-mother relationships than to triangular relationships, to refer to internal persecutory anxiety than to refer to the sense of external persecution; splitting mechanisms, disintegration, an incapacity to make contact, seem to me to be deeper than is anxiety in a relationship.

I think that when we use the word 'deep' we always imply deep in the patient's unconscious fantasy or psychic reality; that is to say, the patient's mind and imagination are involved.

In the course of his 'Opening Remarks on Psychoanalytic Child Psychology' Kris (1951) remarked: 'By extrapolating from psychotic mechanism to early childhood . . .' He was examining critically the relationship between the depth of interpretation in analyses and the earliness of the applicability of psychotic mechanisms to infant psychology. In our analytic work, with the help of our developing concepts, we get deeper and deeper. We are able to see and to use transference phenomena that relate to deeper and deeper elements in the emotional development of our patients. To some extent 'deeper and deeper' does of course imply 'earlier and earlier', but only to a limited extent. We have to take into account the fact that in our analytic patients there has been a fusion of early with later elements.

We have become accustomed to formulating ideas about childhood through what we find in analysis. This came from the work of Freud himself. When applying Freud's work on the origin of psycho-neuroses to the psychology of the child at the toddler age we were not involved in much difficulty, although even here

psycho-analysts were liable to say things which were true in analysis and yet untrue when applied in a crude way to the psychology of childhood.

As we use ideas that take us deeper we take much more of a risk when we apply what we find to the psychology of infancy. Let us consider the Klein concept that is referred to under the title 'the depressive position in emotional development'. It goes deeper, in one sense, and also earlier. Study of ego development would make us unable to accept so complex a matter as the depressive position in an infant younger than six months, and indeed it would be safer to give a later date. If we found references to the depressive position as something that might be found in infants of a few weeks, this would be absurd. What is called by Melanie Klein the 'paranoid position', however, is surely a much more crude thing, almost a matter of talion, and could be perhaps found before integration is a fact. History-taking in the paediatric clinic would indicate that the expectation of retaliation can date from the first days of life. I would therefore refer to the paranoid position as early rather than deep.

As for splitting mechanisms, are these a matter of early or of deep psychology? I suggest that it is important to know the answer because the answer would indicate the ego development and the part played by the mother. We can refer to what is deep as part of the infant, but when we refer to what is early we must take into account the ego-supportive environment that is an important feature at the early stages of extreme dependence.

Now, the direct observer of infants must be prepared to allow the analyst to formulate ideas about very early infancy, ideas which may be psychically true and yet which cannot be demonstrated; indeed it may be possible sometimes by direct observation to prove that what has been found in analysis could not in fact exist at the time claimed because of the limitations imposed by immaturity. What is found repeatedly in analysis is not annulled by being proved to be wrong through direct observation. Direct observation only proves that the patients have been antedating certain phenomena and therefore giving the analyst the impression that things were happening at an age when they could not have happened.

Certain concepts ring true from my point of view when I am doing analysis, and yet ring false when I am looking at infants in my clinic. Kris (1951) goes on to say: 'Observations . . . carried out in a large number of setups confirmed the view of those who stressed the importance of the child's concrete environment for its development.' There is a subtle way in which the concrete

environment may be underrated by many analysts who do nevertheless carefully state that they know and allow for the environmental factor. It is very difficult to get at the bone of contention, yet in a discussion like this we must try to get to it. If deeper and deeper as formulated through analytic work meant earlier and earlier, then it would be necessary to assume that the immature infant of a few weeks could be aware of the environment. We know, however, that the infant is not aware of the environment as environment, especially when the environment is good or good-enough. The environment induces reactions indeed when it fails in some important respect, but what we call a good environment is something which is taken for granted. The infant in the early stages has no knowledge of the environment, knowledge, that is, which could be brought forward and presented as material in analysis. The conception of the environmental has to be added by the analyst.

When an analyst takes us deeper in the understanding of the material presented by the analytic patient, it is not enough for that analyst to state that the external factor is recognized as having its importance. If a formulation of a complete child psychology is being made, one that can be tested by direct observation, the analyst must imaginatively clothe the earliest material presented by the patient with the environment, the environment *that is implied* but which the patient cannot give in analysis because of never having been aware of it. I have illustrated this in my published case description in which the patient had the feeling of being curled up and revolving, in a moment of withdrawal, and I interpreted a medium which was implied but which could not be reported. There is no emotional or physical survival of an infant minus environment. To start with, minus environment the infant would fall infinitely. The infant who is held or who is lying in a cot is not aware of being preserved from infinitely falling. A slight failure of holding, however, brings to the infant a sensation of infinite falling. In analysis a patient may report a sense of falling, dating from earliest days, but can never report being held at this early stage of development.

Deeper and deeper takes us to the instinctual roots of the individual, but this gives no indication of ordinary dependence and dependence which has left no trace on the individual, although these characterize early life.

I would suggest that if this essential difference between depth and earliness be recognized it may be easier for direct observers and analysts to come to terms with each other. It will always be the direct observers who are telling the analysts that they have

made too early an application of their theories. The analysts will continue to tell the direct observers that there is much more in human nature than can be observed directly. In a way there is no difficulty here except a series of interesting theoretical points for discussion. In practice, however, there are certain ways in which it is very important for us to know what is and what is not applicable to earliest infancy.

Psycho-analysis has much to learn from those who make direct observations of infants, and of mothers and infants together, and of small children in the environment in which they naturally live. Also direct observation is not able of itself to construct a psychology of early infancy. By constantly co-operating analysts and direct observers may be able to correlate what is deep in analysis with what is early in infant development.

In two words: a human infant must travel some distance from early in order to have the maturity to be deep.

10

CHILD ANALYSIS IN THE LATENCY PERIOD[1]

(1958)

The subject under discussion is the treatment of the latency child. I have been invited to refer to *psycho-analytic treatment*, and to balance this a colleague has been invited to refer to *individual psychotherapy*. I expect we both start off with the same problem: how to distinguish between the two? Personally I am not able to make this distinction. For me the question is: has the therapist had an analytic training or not?

Instead of contrasting our two subjects each with the other, we might more profitably contrast our two subjects with that of child psychiatry. In my practice I have treated thousands of children of this age group by child psychiatry. I have (as a trained analyst) given individual psychotherapy to some hundreds. Also I have had a certain number of children of this age group for psycho-analysis, more than twelve and less than twenty. The borders are so vague that I would be unable to be exact.

For me, therefore, this discussion should be one between colleagues who are doing the same work, but who are prepared for their work by various training schemes. We would not do well to argue here about the training schemes, though some of these (it will be admitted) are less adequate than others.

It does not surprise me when investigations show that psychotherapy and child analysis give very much the same appearance when written up, regardless of the school from which the therapist derives. If the therapist is suitable by temperament and is able to be objective and to become concerned with the need of the child then the therapy will become adapted to the needs of the case as these present themselves in the course of the treatment.

In this conference I believe we may leave out consideration of therapy based on the various attitudes that are at variance with our own, of which the following would be examples: educational, moralistic, persuasive, punitive, magical, physical.

I must repeat, in order to make it clear, that I feel that there

[1] Read at the 14th International Congress of Child Psychiatry, Lisbon, June 1958, and first published in *A Criança Portuguesa*, **17**, pp. 219–29.

need be no contrast between psycho-analysis and individual psychotherapy. The words can mean the same thing and often do.

As it is my job to speak as one trained in the school of psycho-analysis I must refer, though very briefly, to the nature of psycho-analysis. After this I shall proceed to the discussion of the treatment of the latency child.

The Nature of Psycho-Analysis

It is not thought to be necessary here to do more than to give a reminder of some main principles. Psycho-analysis of children is not different from that of adults. The basis of all psycho-analysis is a complex theory of the emotional development of the infant and child, a theory which Freud initiated and which is constantly being extended and enriched and emended.

The advances in the understanding of the emotional development of the individual have been so rapid in the past twenty or thirty years that it is difficult for the outsider to keep up with these changes through a study of the literature.

The theory assumes a genetic tendency in the individual towards emotional development as towards physical growth; it assumes a continuity from the time of birth (or just before) onwards; it assumes a gradual growth of ego-organization and strength, and the individual's gradual acceptance of the personal instinctual life, and of responsibility for its real and imagined consequences.

Freud established the importance of the repressed unconscious, and in his study of psycho-neurosis he arrived at a central point, undoubtedly the most difficult one in terms of general acceptance, that which he named the Oedipus complex, with castration anxiety as an inherent complication. Freud drew attention to the instinctual life of the individual human child and to the fact that it is in relation to the instinctual life along with the total fantasy of instinct that the main difficulties arise in healthy individuals, that is to say, children who have passed through the essential early stages of emotional development without too much distortion. Psycho-neurosis therefore can be stated as evidence of the strain of ambivalence in relationships between relatively normal 'whole' persons.

Gradually, as is well known, the study of the child led to a formulation of the stages of childhood and infancy development prior to the Oedipus complex, the pregenital roots of genitality. The ego eventually became subjected to study, and so, at last,

analysts began to look at the self of the infant, the infant as a person, a person dependent on someone else.

Melanie Klein (among other things) enabled us to deal with a vitally important stage in the relationship between the child and the mother, that at which a capacity for concern is reached; she also drew attention to the mechanisms that characterize earliest infancy in which the object or the subject itself is split in such a way that ambivalence is avoided. Anna Freud helped to clarify ego defence mechanisms. The work of various (mainly) American analysts has taken us to the study not simply of the mechanisms that are characteristic of earliest infancy but to the young child, the child as a person dependent on child-care. I myself have played some part in the attempt to make a statement of the earliest phases in which the infant is merged in with the mother and (by a complex and precarious mechanism) emerges, and consequently must deal with the relationship to objects that are not part of the self.

All these developments make the study of psycho-analysis very exciting and highly significant for the student of mental disorder and its prevention.

Diagnosis

Psycho-analysis as a treatment cannot be described without reference to the diagnosis. The classical psycho-analytic setting is related to the diagnosis of psycho-neurosis, and it might be convenient to speak only of psycho-neurosis. Here indeed is a big enough subject for many conferences, but what is expected today is a comprehensive statement in a few words of psycho-analysis, whatever the diagnosis, including the normal. It must be emphasized, though the theme cannot be developed in this setting, that in the technique of psycho-analysis there are very big differences according to whether the child is neurotic or psychotic or anti-social.

It should be added, for completeness, that the difference between the child and the adult is that the child often plays rather than talks. This difference, however, is almost without significance, and indeed some adults draw or play.

The Transference

It is characteristic of psycho-analysis that the analyst does not waste the valuable material that comes up for analysis in terms of the emotional relationship between patient and analyst. Here in the unconscious transference appear samples of the personal pattern of the patient's emotional life, or psychic reality. The analyst

learns to detect these unconscious transference phenomena and, by using the clues supplied by the patient, is able to interpret that which is just ready for conscious acceptance at any one session. The most fruitful work is that which is done in terms of transference.

Our discussion here could usefully aim at describing the transference as it appears characteristically in the latency period.

Psycho-Analytic Technique Adapted to the Latency Child

It is now necessary to consider the peculiarities of psychoanalysis when this form of treatment is adapted to the age group under discussion. It is generally conceded that the most rewarding age group for the analyst, especially for the beginner, is the first group, in which the child is two, three or four years old. After the passing of the Oedipus complex, there develop tremendous defences.

Nature of Latency

It is not yet certain what constitutes the latency period. Biologically it would seem necessary to assume that in these few years, 6–10, the development of instinct ceases, so that for the time being the child is left with an instinctual life based on what has been built up in the earlier period. Changes will begin to occur again at puberty, and then again the child will be needing to organize against an altering state of affairs; to be on the alert against new anxieties and to have the excitement of enjoying new experiences and new satisfactions, and new degrees of satisfaction.

Whatever else may be said about the latency period it seems fairly clear that there are big defences organized and maintained. Here we find agreement between the two main writers on this subject, Melanie Klein and Anna Freud. In her chapter on the latency period in *The Psycho-Analysis of Children* (1932) Melanie Klein starts by referring to the special difficulties of the latency period. 'Unlike the small child', she says, 'whose lively imagination and acute anxiety enable us to gain an easier insight into its unconscious and make contact there, they (latency children) have a very limited imaginative life, in accordance with the strong tendency to repression which is characteristic of their age: while, in comparison with the grown-up person, their ego is still undeveloped and they neither understand that they are ill nor want to be cured, so that they have no incentive to start analysis and no encouragement to go on with it.'

Anna Freud's book, *The Psycho-Analytical Treatment of Children*

(1946) is concerned in the first chapter with the discussion of an introductory phase which is necessary in the analysis of children. From the examples given it can be seen that Miss Freud is referring chiefly to children of the latency period, although not entirely so.

If one reads these two books, each of which is full of infinite richness and indicates vast clinical experience which we can well envy, one can either see similarities or differences. Similarities certainly there are and they concern this matter of the altered technique which is necessary for the latency child. What is not made clear is that many of the differences concern diagnosis.

In regard to other differences, and it is these that we wish to study, we can note immediately that Melanie Klein finds it good to interpret the unconscious conflicts and the transference phenomena as they arise, and to form a relationship with the child on the relief given by such interpretations; by contrast Miss Freud tends to build up a relationship with the child on a conscious level and she describes how she gets gradually to the work of the analysis with the conscious co-operation of the patient. The difference is largely a matter of *conscious or unconscious co-operation.*

It would seem to me to be possible to exaggerate the differences here, although they may be real enough in certain instances. In my opinion, the sooner the analyst interprets the unconscious the better, because this orientates the child towards analytic treatment, and the first relief undoubtedly gives the first indications to the child that there is something to be got out of analysis. On the other hand, it is possible to lose latency patients in the initial stages through not gaining their conscious co-operation. We may hand over to the parents the introduction of the child to an intellectual understanding of the need for treatment, and in this way may escape responsibility for the introductory phase in the child's analysis. But it makes a great deal of difference how the parents or the guardians of a child give an idea to the child of what is to be expected from this daily treatment session. Miss Freud deliberately takes over the burden of explaining to the child what is happening, and Mrs Klein leaves this to those who are bringing the child, hoping to be able to do without explanations on a conscious level by getting quickly to the unconscious co-operation, that is, co-operation that is based on the work of the analysis.

It is necessary for us to deal with the situation as we find it in each case that we treat. With very intelligent children we need to be able to talk to their intelligence, to feed their intelligence. It is sometimes a complication when we are doing work with a

child and the child feels that something is going on, and yet has no intellectual understanding of what it is all about. In any case it would seem to be a pity to waste the intellectual understanding of the child, which can be a very powerful ally, although of course in certain cases the intellectual processes may be used in defence, making the analysis more difficult.

To some extent at this point we are again talking about diagnosis. Where there is anxiety of psychotic intensity, there is a great need for help and help must be given immediately, and yet even so the intellect can be met. I am thinking at the moment of a boy of ten. As I came into the room when I first met him he was saying to his mother: 'But you don't understand, it's not the nightmare I'm frightened of; the trouble is that *I'm having a nightmare while I'm awake.*' In these words he was giving a true description of his illness and I was able to start at this point, working both with his very fine intellect and also giving interpretations at all levels, including the deepest.

In trying to sort out the various opinions which are expressed and which I personally feel, I find myself wishing to quote Berta Bornstein, from her paper 'On Latency' (1951). She starts: 'From the standpoint of the intellectual ability of the child in latency, we could expect the child to associate freely. The factors responsible for the child's failure to do so create a general limitation of child analysis. There are several reasons for his inability to associate. In addition to those well known to us, I will mention only one which has not been stressed yet: *Free association is experienced by the child as a particular threat to his ego organization*' (my italics).

I find this way of looking at the latency period very helpful. I have no time here to refer to Berta Bornstein's division of the latency period into phases. In a general way, however, it seems to be important that we should realize when we are treating children of this age that they have achieved a sanity and they have left the primary process. Their ego achievement must not be broken into. This same chapter ends with the following words: 'The utmost care has to be exercised in the analysis of latency to strengthen weak structures and to modify those which interfere with normal development. The selection of material for interpretation and the form of interpretation itself must be geared to these ends.' For this reason we co-operate with the child in all sorts of activities while gathering material for the mutative interpretation.

Berta Bornstein also refers to Freud's (1905a) 'ideal of latency', that is to say, the successful warding off of instinctual demands.

I am thinking of an exercise book that I have in my possession. Each page of this book represents very constructive work done by a girl in the latency period. Hers is one of those difficult cases in which one can say that almost her only symptom was bed-wetting. Behind this lay a character disorder that was only too successfully dove-tailed in with the mother's own homosexual repression. The characteristic of this exercise book as one looks at it is that it is mainly composed of very well-constructed pictures done with coloured chalks. The analysis was extremely boring for me. The girl seemed to blot me out. Of the fifty or so pictures only two or three in the middle lose the characteristic of organized defence. These two or three show every kind of breakdown, a mess and a muddle, disintegration; and, in one of them, a breast-like object is cut out with scissors and left separate lying between the leaves. Here is oral sadism and also incontinence and a fantasy of incontinence. If this child had been three years old it would have been much easier to have got at the *child* incontinent or disintegrated; but because she was in the latency group I had to be contented with reaching to an *illustration* of her hidden madness. Whereas a small child is often 'mad' and yet healthy, because naturally controlled by those in care, a latency child who is 'mad' is very seriously ill, and needs nursing.

My contribution here is a development of the accepted theme of the latency period as the period in which the ego comes into its own, so to speak. In health the latency child is not compelled to bow to id-demands, though id-drives maintain force and appear in all manner of indirect forms.

Of all that could be said I choose to say here that in the latency period:

(1) The child is in one sense alone, though needing to be with others who are similarly placed. Relationships between healthy latency children can be intimate over long periods, without becoming sexualized in a manifest sense. The sexual symbolism holds. The manifest sexual elements of deprived children disturb play and ego-relatedness.

(2) The latency child is ready for introjecting, but not for incorporating—ready to take in whole elements from chosen persons but not ready to eat or be eaten, or to merge in an intimate relationship involving instinct.

(3) The latency child is a specialist in the display of inner phenomena without becoming directly involved in the full life. Persistence of the latency phase may show in an adult's capacity for ego achievement at the expense of id-freedom.

(4) Sanity is essential in the latency phase, and the child in this

phase who cannot maintain sanity is clinically very ill. The ego-organization carries the drive which both earlier and later is partly carried by id-impulse.

Time to Interpret

I think that it is the earliest possible moment that is the right moment for an interpretation, that is to say *the earliest moment at which the material makes it clear what to interpret.* But I am economical in my interpretations, and if I am not sure what to interpret I have no hesitation in playing for time. In playing for time I find myself involved in an introductory or preparatory phase, playing, constructing with the child, or just being blotted out, wasted. I would be concerned, however, with only one thing, the search for the clue which makes possible the interpretation that is the appropriate one at the moment, the interpretation that brings about a shift of emphasis in the unconscious transference.

Perhaps a statement such as this one could meet with general acceptance. Some analysts are more quick than others to pick up the clue, and there is room for the quick and the slow in this work. What matters to the patient is not the accuracy of the interpretation so much as the willingness of the analyst to help, the analyst's capacity to identify with the patient and so to believe in what is needed and to meet the need as soon as the need is indicated verbally or in non-verbal or pre-verbal language.

The End of the Treatment

Finally I will ask you to consider the ending of analysis. Of course it is always necessary to think in terms of the individual case and the diagnosis, but there is something of general significance that can be said. In the analysis of small children the analyst is considerably helped by the tremendous changes that take place naturally in the child of five, six, or seven years of age. At the time when the early analysis is ending these growths are taking place, facilitated no doubt by the success of the analysis. Any improvement due to analysis is in this way *exaggerated* by the natural course of events. Especially in regard to the socialization of the child it is often easy for those who are in charge of the child to be pleased with the result, because the child loses the wildness and changeability of the pre-latency era and becomes more happy in groups. By contrast the *latency analysis tends to end at a very awkward time.*

It would be interesting to hear this matter discussed. Typically the analysis is ending when the child is eleven or twelve and the complications of pre-puberty and of puberty itself are appearing.

It is perhaps advisable to plan analyses so that they either end before the onset of puberty or else in such a way that they may continue right on through the first years of the new developments. It may be that some analysts, in following the latter course, see their patients at relatively infrequent intervals, keeping in touch with them, and expecting to be needed five times a week over certain periods of time during the puberty era. Apart from the actual changes of puberty, there may so easily be incidents, traumatic friendships, grand passions, seductions, masturbation anxieties, which lead to exacerbations of defences or to frank anxiety.

The question arises: what place is there for the analysis confined to the latency age, for instance, from six to ten? How far during this period of relative calm in the instinctual world can the analyst claim to know the child? How far can the analyst deduce from what happens in such an analysis what the child was like at three or predict what the child will be like at thirteen? I am not sure of the answers to these questions but I know that I personally have been deceived, sometimes making a prognosis too favourable and sometimes not favourable enough. It is probably more easy to know what to do when the child is ill because then the obvious illness dominates the scene and treatment is not considered to be finished while the child's illness remains. When the child is relatively well then it is not lightly that anyone will put his or her latency child in analysis.

One analyst cannot have enough cases to cover all contingencies, and it is therefore necessary for us to pool experiences, not being afraid to make suggestions which turn out to be stupid when examined by a group. Each analyst builds up a highly specialized experience, rich indeed, but needing to be related to the experiences of colleagues doing the same work, but with other children.

11

CLASSIFICATION: IS THERE A PSYCHO-ANALYTIC CONTRIBUTION TO PSYCHIATRIC CLASSIFICATION?[1]

(1959–1964)

This chapter is intended as a preliminary contribution calling attention to the importance of the subject, given in the hope that it will lead to a discussion in which analysts with various types of experience will take part.

Before making my own specific contribution, in which I indicate why I do believe that psycho-analysis has a contribution to make to classification, I must attempt an historical sketch. This sketch will be inadequate and perhaps inaccurate, but if I omit this task I have no background against which to give my opinion as to the profound effect that recent psycho-analytic developments have had on our attitude to psychiatric classification. The recent developments that I refer to are the concept of the false self, the linking of psychopathy with deprivation, and the understanding that psychosis takes origin at a stage at which the immature human being is truly dependent on environmental provision. These three ideas have been chosen because they have interested me personally.

Historical

In the early days of psycho-analysis Freud concerned himself with three aspects of psychiatric illness. One was behaviour, the patient's relation to reality. The second was symptom-formation, which Freud established as a *communication*, this concept being part of his new understanding of the unconscious. The third was aetiology, which Freud transformed by introducing the idea of the developmental process. Freud studied the development of the instinctual life and this involved him in the theory of childhood sexuality, which eventually led to the theory of the pregenital instinctual life of the human infant and to the concept of the fixation points. The aetiology of psychiatric disorder now demanded of the clinician an interest in history-taking. In this way the

[1] Read at Scientific Meeting of the British Psycho-Analytical Society, 18 March 1959.

psycho-analysts became pioneers in psychiatric history-taking, and it is they who have recognized that the most important part of history-taking derives from the material arrived at in the course of psycho-therapy.

In a classification based on those areas of interest which Freud covered in the early years of his work the patients were either psychotic or hysterical. I should say in passing that Freud was always interested in the constitutional factors.

At the beginning of the second decade of the century Freud began to develop his structural view of the personality. The ego, the id, and the censor were concepts which led to a clearer study of intrapsychic conflict, and intrapsychic equilibrium was taken as evidence of successful defence. The quality as well as the quantity of the processes in the ego became significant. The concept of the superego eventually became formulated and was at first thought to be a result of massive introjections and identifications, dating from the two- to five-year-old period, and from the time of the full-blown Oedipus complex. The story of pregenital instinctual development led to an elaboration of the idea of regression to fixation points. Fixation points were points of origin of illness-types. They indicated that anxiety (being intolerable) had involved the individual in the organization of defences of pathological degree or kind with the result that further progress in instinctual development was hampered. Classification became related to these fixation points, as well as to the ego mechanisms of defence, which were eventually to become stated exhaustively in psycho-analytic terms by Anna Freud (1936). At the centre of all this is castration anxiety and the Oedipus complex. The disorders are the psycho-neuroses.

Already Freud had introduced the idea of dependence (anaclitic object-love) (Freud, 1914) and the matter of ego-weakness and -strength became significant in psycho-analytic metapsychology. In this way a language was found for the description of the borderline case and of character disorders. Narcissistic elements in the patient were all the time considered to be indications of an ego disorder making psycho-analysis unlikely to be effective because of the weakening of the capacity of the patient for the development of a transference neurosis (Freud, 1937).

Gradually and in the course of time the study of psychosis began to make more sense. Ferenczi (1931) contributed significantly by looking at a failed analysis of a patient with character disorder not simply as a failure of selection but as a deficiency of psycho-analytic technique. The idea implied here was that psycho-analysis could learn to adapt its technique to the

character disorder or the borderline case without turning over into management, and indeed without losing the label psycho-analysis. Eventually Melanie Klein (1932, 1948) made her specific contributions showing that in the analysis of children psychotic disorders must be encountered, and that these could be dealt with if met by adequate technique, so that failure to deal with psychotic manifestations in childhood meant for her (as for Ferenczi) a failure of technique, not a failure of selection.

Then the concept of the setting of the analysis began to widen. Already Aichhorn (1925) had shown that special technical adaptations must be made when the patient is an antisocial case. At first Aichhorn's work may have given some alarm because he was acting in a way which would be 'bad analysis' in the treatment of a case of hysteria or a case of obsessional neurosis. It is now possible to see that Aichhorn was a pioneer and initiated a genuine movement towards an adaptation of the psycho-analytic technique to meet the needs of the psychopath or of the deprived child with an antisocial tendency.

All these developments tended to make the early history of each case more and more important. Just here a dichotomy seemed to arise in psycho-analytic circles. I would say that Melanie Klein represents the most vigorous attempt to study the earliest processes of the developing human infant *apart from the study of child-care.* She has always admitted that child-care is important but has not made a special study of it. On the other hand there have been those who developed an interest in the child-care and infant-care techniques. Those who did this always ran the risk of being considered traitors to the cause of the internal processes. The work of Miss Freud and Mrs Burlingham in the Hampstead War Nursery (Burlingham and Freud, 1944) led to a development of the study of external conditions and their effect. It is clear that this dichotomy between those who almost confine their researches to a study of the internal processes and those who are interested in infant-care is a temporary dichotomy in psycho-analytic discussion, one which will eventually disappear by natural processes (cf. Hartmann, 1939; James, 1962; Kris, 1950).

Now we see the ego of the infant as something dependent at first on ego-support, something which derives structure and strength from a highly complex and subtle system of adaptation to need, this adaptation being supplied by the mother or mother-figure. Also we see the interesting process of the absorption into the individual child of the child-care elements, those which could be called 'supporting ego' elements. The relationship between

this absorption of the environment and the introjection processes with which we are already familiar provides great interest. Along with all this goes a study of the mechanisms by which the infant emerges from a state of being merged in with the mother, a process that demands of the mother a capacity to hate as well as to love. In the theory of the emotional development of the child the gradual establishment of the individual as a separate person becomes a matter of central importance, and these matters belong to present-day research. Classification must be affected by these theoretical formulations.

As a result of these new developments narcissism in the clinical condition is seen in a new light. It is as if in looking at narcissistic illness the clinician is liable to be caught up with the absorbed, or internalized, environment, and to mistake this (unless well prepared) for the real individual, who in fact is hidden and is secretly loved and cared for by the self within the self. It is the true individual that is hidden.

These developments lead to a reconsideration of other concepts. The concept of the death instinct seems to disappear simply through being unnecessary. Aggression is seen more as evidence of life. Under favourable conditions, fusion occurs between the erotic and the motility impulses, and then the term oral sadism becomes applicable, followed by all the developments of this theme. This is matched by the mother's wish to be imaginatively eaten. Failure of fusion, or loss of fusion that has been achieved, produces a potential element of pure destructiveness (i.e. without guilt-sense) in the individual, but even this destructiveness remains a lifeline in the sense of its being the basis of object relationships that feel real to the patient.

Fusion of the two roots of instinctual impulses (aggressive and erotic) belongs to a stage in infant development in which there is very great dependence. There is no possibility whatever that an infant whose environment is insufficiently adapted to the needs of an infant near the beginning may reach to a state of fusion of the aggressiveness (which makes object relationships feel real, and makes objects external to the self) and of the erotic desires (which carry a capacity for libidinal satisfaction).

Furthermore, the concept of regression has changed its meaning in psycho-analytic metapsychology. For many years the term carried with it an implication of a return to earlier phases of the instinctual life, and regression was to a fixation point. This belongs to the view of primitive instinctual elements in the individual, with child-care taken for granted. In the study of the *actual* infant it is no longer possible to avoid taking into account

the environment, so that in speaking of an actual infant one must mention dependence and the nature of the environment. The term regression therefore has now a clinical application in *regression to dependence*. It is a tendency towards a re-establishment of dependence and therefore the behaviour of the environment becomes something that cannot be ignored if the word regression is used. The term regression continues to contain the idea of regression to primary process. The tendency to regression in a patient is now seen as part of the capacity of the individual to bring about self-cure. It gives an indication from the patient to the analyst as to how the analyst should behave rather than how he should interpret. Associated with this subject is the clinical fact of self-cure through a process of regression which is very commonly met with outside psycho-analytic treatment.

Psychosis is no longer to be ascribed to a reaction to anxiety associated with the Oedipus complex, or as a regression to a fixation point, or to be linked specifically with a position in the process of the individual's instinctual development. Instead it could be postulated that the regressive tendency in a psychotic case is part of the ill individual's *communication*, which the analyst can understand in the same way that he understands the hysterical symptom as a communication. The regression represents the psychotic individual's hope that certain aspects of the environment which failed originally may be relived, with the environment this time succeeding instead of failing in its function of facilitating the inherited tendency in the individual to develop and to mature.

In the course of the vast expansion of theory which I have sketched here there came a development which enabled the clinician to begin to be able to relate mood disorder to the general scheme of psycho-analytic metapsychology. Early formulations had made possible a statement of health in negative terms, as an absence of rigid defence or as an absence of fixations, and in positive terms as a matter of ego-strength. There now appeared something which made it possible for the first time in psycho-analytic metapsychology to speak of *value* in the personality. This came through Freud's development of an idea of Abraham's in 'Mourning and Melancholia', and the elaboration of this theme by Klein. Now the affective disorders began to fall into place, and the way was prepared for a statement of the relationship between depression and concern. Here Melanie Klein made her most significant contribution, enriching our ideas of the superego, and introducing the idea of primitive superego elements derived from the instinctual life of the infant. Such super-

ego elements take origin prior to the phase of the full-blown Oedipus complex, or the ambivalencies associated with the inter-relationships between three 'whole' personalities.

This is not the place for a restatement of the very considerable metapsychological developments that follow from this work of Melanie Klein. This work relates the contending forces that operate within the self to the instinctual life, and relates the patterns of defences that organize within the self to mood. There follows a vast extension of the understanding of the representations of an individual's inner psychic reality in his or her mental life.

Melanie Klein's work has altered psychiatric classification by separating out two kinds of depression the one from the other. One kind represents an achievement in emotional development almost synonymous with the acquisition of a capacity to be responsible, or a capacity to feel a sense of guilt, and the other (with depersonalization and other features that could be referred to as 'schizoid') represents a failure initiated at an early stage, before the establishment of what Melanie Klein calls the 'depressive position' in emotional development.

From this work one naturally turns to hypomania as a clinical expression of the manic defence, a denial of depression that is a fact; and also to the manic-depressive swing, which implies a dissociation, a dissociation in the patient between control of unfused aggression and of introjected omnipotent elements, and possession by these elements.

On the basis of this statement it is possible to glance at the large subject of classification today.

Psycho-Neurosis and Psychosis

It is probably a matter of general agreement among analysts that there is value in the use of the two words *psycho-neurosis and psychosis.*[1] Here is a simple classification of all mental disorders.

I am, of course, referring to disorders of emotional development and not to such illnesses as primary mental defect, post-encephalitis states, arteriosclerotic brain, G.P.I., etc., etc. Where there is disease or disorder of the brain itself there is naturally a secondary disorder of the personality, but this complication need not be included in this preliminary contribution. It is the psycho-analysts who have put forward and developed the psycho-genic theory of the psycho-neuroses and the psychoses; or perhaps one should say psycho-analysts have retained some of the view of

[1] I deliberately leave out 'actual neurosis' in this context.

mental disorder which was prevalent before the more mechanistic view which reached the climax half a century ago and which still dominates non-analytic psychiatry generally.

The term psycho-neurosis implies to analysts that the patient as an infant and child reached to a certain stage of emotional development and that, genital primacy and the stage of the Oedipus complex having been achieved, certain defences against castration anxiety have become organized. These defences constitute psycho-neurotic illness, and the degree of illness is reflected in the degree of rigidity of the defence. This is of course a gross over-simplification, but psycho-analysts have found that castration anxiety is central in psycho-neurotic illness, although it is recognized that the pattern of the illness is variable according to the pregenital experiences of the individual. Where annihilation anxiety, not castration anxiety, is found as an important feature, then on the whole the psycho-analyst will consider that the patient's diagnosis is not psycho-neurosis but psychosis. It is to some extent a matter of whether the threat is in terms of part object or whole object.

The various types of psycho-neurotic illness are best grouped around the types of defence, the central being repression. I shall not enumerate these. Psycho-analysis as we teach it is primarily based on the treatment of psycho-neurosis and we attempt to choose cases for our students which are suitable for this kind of teaching although we recognize that with the best possible selection some cases will have disturbances that go deeper (i.e. notably depression appears either in the quality of the anxiety or as a mood disorder).

The psychology of psycho-neurosis leads the student immediately to the repressed unconscious and to the instinctual life of the individual. The instinctual life has to be considered both in terms of the bodily functions and of the imaginative elaboration of these functions. (By instinctual one means what Freud called sexual, i.e. the whole range of local and general excitements which are a feature of animal life; in the experience of these there is a period of preparation, an act with climax, an aftermath.)

Further treatment of this theme would lead to a repetition of a large part of classical Freudian theory. In using the term psycho-neurosis there is an implication that the individual's personality is intact, or, in terms of development, that the personality has been constructed and is being maintained and that a capacity for relationships to objects is intact. (Also it is implied that the individual's character is not markedly distorted by resentment or by more organized psychopathic trends.)

Leaving out mood disorder, for the moment, I now refer to psychosis[1] in order to reach to the points of contrast.

The term *psychosis* is used to imply either that as an infant the individual was not able to reach to the degree of personal health which makes sense of the concept of the Oedipus complex, or alternatively that the organization of the personality had weaknesses which became revealed when the maximal strain of the Oedipus complex had to be borne. It will be seen that there is a very thin line between this second type of psychosis and psychoneurosis. In the extreme of the first type of psychosis there is but little resemblance to psycho-neurosis, since no significant Oedipus stage has ever been reached, and castration anxiety was never a major threat to an intact personality.

In some cases of clinical psychosis what we see represents a *breakdown of defences*; new defences may come to be set up of a yet more primitive kind but the clinical picture is dominated by a breakdown in defences, at any rate temporarily; this is what is ordinarily meant by mental breakdown; defences have become unsatisfactory, and the patient has to be nursed while new defences are being organized.[2] In the organization of defences the individual is affected by all manner of environmental factors, and also hereditary tendencies may sometimes have specific importance. Behind all mental breakdown is theoretically a state of chaos but complete breakdown must be rare clinically, even if it is possible, as it would indicate an irreversible change away from personal growth towards fragmentation.

Just as a study of *psycho-neurosis* leads the student to the Oedipus complex and to the triangular situations that reach their height in the child at the toddler age and again in adolescence, so the study of psychosis leads the research worker to the earliest stages of infant life. This implies the infant-mother relationship since no infant can develop outside such a relationship. (It involves the idea of dependence prior to the establishment of the operation of the mechanisms of projection and introjection.)

[1] I realize that the word 'psychosis' presents all manner of difficulties. In a way I am claiming a meaning for the word at a time when there are many who would like to see the word dropped. I suggest, however, that there is still a use for this term to cover emotional disorder that is not included in the terms psycho-neurosis or neurotic depression. I am aware that in psychiatry the term psychosis is used to describe various syndromes which have a physical basis. Here is another source of confusion. I cannot see, however, that anything can be gained from inventing a new word.

[2] See a later note on the subject of mental breakdown, given at the end of this chapter.

General Comment

Probably the most important contribution from psycho-analysis to psychiatry and to psychiatric classification is the destruction of the old idea of disease entities. Here the psycho-analyst is right at the other end of the pole from the kind of psychiatrist who thinks that there is a disease, schizophrenia, and another disease, manic-depressive psychosis, and so on (cf. Menninger *et al.*, 1963).

The psycho-analyst, as I have already said, can be looked upon as a specialist in history-taking. It is true that this history-taking is a very involved process. A psycho-analytic case description is a series of case histories, a presentation of different versions of the same case, the versions being arranged in layers each of which represents a stage of revelation. The analyst gets a view of mental disorder which is very different from that of the psychiatrist who makes a very careful examination of a patient at a certain moment in the history of the case, as for instance when there has been a breakdown or when hospitalization has occurred.

It is possible to trace a disorder in a patient from childhood through adolescence and through early and late adult life, and to see the way in which there has been a transmutation all along the line from one type of disorder to another. In this way it is impossible for the analyst to retain any idea he may have had from his formal psychiatric training that there are definite psychiatric diseases. In fact it becomes evident to the analyst in the course of his analytic work that in so far as psychiatry concerns diagnosis it is making a tremendous attempt to do the impossible, since a patient's diagnosis not only becomes clearer as analysis proceeds but also the diagnosis alters. An hysteric may reveal underlying schizophrenia, a schizoid person may turn out to be the healthy member of an ill family grouping, an obsessional may turn out to be a depressive.

Practising psycho-analysts would agree that there is a gradation from normality not only into psycho-neurosis but also into psychosis, and the close connexion between depression and normality has already been stressed. It may be true that there is a closer link between normality and psychosis than between normality and psycho-neurosis; that is to say, in certain respects. For instance, the artist has an ability and the courage to be in touch with primitive processes which the psycho-neurotic cannot bear to reach, and which healthy people may miss to their own impoverishment.

POSITIVE SUGGESTIONS

I can now come to the positive suggestions which I wish to make for discussion at this preliminary stage. Let it be understood that I recognize the immense value of classical psychiatric classifications.

My concern is with the effect on classification of some of the newer ideas (or perhaps these are old ideas given new emphasis, or wrapped up in new language?). I shall choose matters which I personally have studied and have tried to elucidate in various papers. The same ideas have been introduced independently into the literature by other analysts, but it would confuse the issue if I were to attempt to quote, or to compare the various terms used by these other writers with those used by myself.

I give special consideration to:

(i) The idea of the true and the false self.

(ii) The idea of delinquency and psychopathy as derivations of perceived, actual emotional deprivation.

(iii) The idea of psychosis as related to emotional privation at a stage before the individual could perceive a deprivation.

(i) *False Self*

The concept of the false self (as I call it) is not a difficult one. The false self is built up on a basis of compliance. It can have a defensive function, which is the protection of the true self.

A principle governing human life could be formulated in the following words: only the true self can feel real, but the true self must never be affected by external reality, must never comply. When the false self becomes exploited and treated as real there is a growing sense in the individual of futility and despair. Naturally in individual life there are all degrees of this state of affairs so that commonly the true self is protected but has some life and the false self is the social attitude. At the extreme of abnormality the false self can easily get itself mistaken for real, so that the real self is under threat of annihilation; suicide can then be a reassertion of the true self.

Only the true self can be analysed. Psycho-analysis of the false self, analysis that is directed at what amounts to no more than an internalized environment, can only lead to disappointment. There may be an apparent early success. It is being recognized in the last few years that in order to communicate with the true self where a false self has been given pathological importance it is

necessary for the analyst first of all to provide conditions which will allow the patient to hand over to the analyst the burden of the internalized environment, and so to become a highly dependent but a real, immature, infant; then, and then only, the analyst may analyse the true self. This could be a present-day statement of Freud's *anaclitic dependence* in which the instinctual drive leans on the self-preservative. Dependence of the schizoid patient or of the borderline case on the analyst is very much a reality, so much so that many analysts prefer to avoid the burden and they select cases carefully. In selecting cases for analysis analysts must therefore take into account the common existence of a false self. Selection requires in the clinician an ability to detect the false-self defence, and when this is detected the clinician must then decide whether this is likely to be a positive help in the analysis, or whether in a particular case it is pathologically powerful and indicates so severe an initial handicap in emotional development that psycho-analysis had better be left out of consideration.

I suggest that 'false self' is a valuable classificatory label, one that almost absolves us from further diagnostic effort. It is in this type of case, not uncommon, that psycho-analysis can be dangerous, that is if the analyst is taken in. The defence is massive and may carry with it considerable social success. The indication for analysis is that the patient asks for help because of feeling unreal or futile in spite of the apparent success of the defence.

A special case of the false self is that in which the intellectual process becomes the seat of the false self. A dissociation between mind and psyche-soma develops, which produces a well-recognized clinical picture. In many of these cases there is probably an especially high intellectual endowment, and this may contribute to the building up of the syndrome although the high I.Q. on test may result from the dissociation.

(ii) *Psychopathy*

First, I must try to define the word psychopathy. I am using the term here (and I believe I am justified in doing so) to describe an adult condition which is an uncured delinquency. A delinquent is an uncured antisocial boy or girl. An antisocial boy or girl is a deprived child. A deprived child is one who had something good-enough, and then no longer had this, whatever it was, and there was sufficient growth and organization of the individual *at the time of the deprivation* for the deprivation to be perceived as traumatic. In other words, in the psychopath and the delinquent and the antisocial child there is logic in the implied attitude 'the environment owes me something'. I personally believe

that in every case of antisocial organization there was a point at which a change occurred, with the individual able to appreciate the fact. This appreciation of course is not usually conscious, but the point of deprivation may be remembered, unless it has become lost among innumerable successive deprivations.

The main thesis here is that the maladjustment and all the derivatives of this type of disorder consist essentially in an original maladjustment of the environment to the child, the maladjustment not having occurred early enough to produce psychosis. The accent is on environmental failure and the pathology is therefore primarily in the environment and only secondarily in the child's reaction. The classification of delinquents and psychopaths ought logically to be in terms of the classification of environmental failure. It is for this reason that there is a confusion immediately if an attempt is made to bring psychopathy and recidivism and the antisocial tendency into line with other labels such as neurosis and psychosis.

This argument leads to:

(iii) *The Question of Psychosis and Classification*

If it be true that the disorders which come under the wide heading of psychosis (and which comprise the various types of schizophrenia) are produced by environmental deficiency at a stage of maximal or double dependence, then the classification has to be adapted in order to meet this idea. Such a development would certainly have surprised psycho-analysts of thirty years ago, most of whom, in considering psychosis, would have started off with an assumption that very primitive mechanisms were aetiologically significant in such illness. Today, I suggest, we are coming round to the view that in psychosis it is very primitive *defences* that are brought into play and organized, *because of environmental abnormalities*. We can of course see the very primitive mechanisms at work in psychotics as also in our 'normal' patients, and indeed in all people. We cannot diagnose psychotic illness by finding primitive mental mechanisms. Of course, in psychotic illness it is the primitive defences that we meet with, defences which do not have to be organized if in the earliest stages of near-absolute dependence the good-enough environmental provision does in fact exist. Justice can be done to all the factors by the statement that the individual's maturational processes (including all that is inherited) require a facilitating environment, especially in the very early stages. Failure of the facilitating environment results in developmental faults in the individual's personality development and in the establishment of

the individual's self, and the result is called schizophrenia. Schizophrenic breakdown is the reversal of the maturational processes of earliest infancy.

I am suggesting that in a study of psychosis the attempt must be made to classify the environment and the types of environmental abnormality, and the point in the development of the individual at which these abnormalities operate, and that to attempt to classify sick individuals on the basis of the clinical pictures that they present leads to no useful result. I repeat: the environmental deficiencies which produce psychosis belong to the stage prior to that at which the developing individual has the equipment to be aware of either the environmental provision or its failure (cf. the antisocial tendency). It will be seen that in attempting to date the onset of psychosis I am therefore referring to the degree of the individual's dependence and not to the individual's pregenital instinctual life, nor to the stage of the infant's erotogenic zone primacy.

The argument has been developed here on the basis of extremes. In our clinical work we meet mostly with patients who are to some extent or under certain conditions healthy, but who can be ill, so that it can be said that they bring their illness to us for treatment as a mother might bring a sick child.

Inherent Conflict

Let us now look at the internal factors, those which concern us as analysts. Apart from the study of healthy persons, it is perhaps only in *psycho-neurosis* and *reactive depression* that one may get near to the truly *internal* illness, the illness that belongs to intolerable *conflict* which is inherent in life and in living as whole persons. It might be a definition of relative psychiatric health that in the healthy one can genuinely carry the difficulties that the individual encounters back to the inherent struggle of individual life, the (unconscious) attempt of the ego to manage the id and to use id-impulse in the fullest possible way in relationship with reality. It is important for me to make this clear because some may feel that in putting forward a method of classifying which includes a classification of environment I am leaving aside all that psychoanalysis has gained in the study of the individual.

Without attempting to review the literature I wish to refer to the writings of two of my teachers, Rickman and Glover. Rickman's 1928 lectures had a big influence on the development of my thought but I am not aware that Rickman dealt with the importance of dependence.

In Edward Glover's *On the Early Development of Mind* (1956) there are many references to classification. I think there are only two references in this book to the environment of the kind that I am developing into a main theme. On page 174 there is the sentence: 'An instinct that requires a true external object, such as the mother's nipple, is unmasterable unless with the collusion of the real object.' This is from a 1932 lecture, entitled 'A Psycho-Analytic Approach to the Classification of Mental Disorders'. The other reference comes in his 1949 statement in the *British Medical Bulletin* on 'The Position of Psycho-Analysis in Great Britain' (Glover, 1949). After painting rather a gloomy picture of the state of affairs in the British Society he puts forward the following comment: 'But when all is said, the present is an interesting phase in the history of psycho-analysis. However absurd some of the hypotheses recently advanced may have been, there is no doubt that the focusing of interest on problems of early ego-development and on the organization of mind during the phase of "primary identification" (i.e. at the stage before the "self" and the "not-self" are accurately differentiated), will in the long run produce results of value both diagnostically and therapeutically.'

I wish also to refer to Ackerman (1953), who however does not seem to concern himself with the special feature of dependence at a very early date.

Classification According to Environmental Distortion

I think it might be valuable to classify according to the degree and quality of the environmental distortion, or deficiency, that which can be recognized as aetiologically significant. It is necessary to look at this point of view, even if only to reject it.

In the case of any individual at the start of the process of emotional development there are three things: At one extreme there is heredity; at the other extreme there is the environment which supports or fails and traumatizes; and in the middle is the individual living and defending and growing. In psycho-analysis we deal with the individual living, defending and growing. In classification, however, we are accounting for the total phenomenology and the best way to do this is first to classify the environmental states; then we can go on to classify the individual's defences, and finally attempt to look at heredity. Heredity, in the main, is the individual's inherent tendency to grow, to integrate, to relate to objects, to mature.

Classification in terms of environment would require a more

accurate knowledge than at present exists, as far as I know, of the stages of dependence. For the time being I find it valuable to use the concepts which I have put forward in other papers, of independence arising out of dependence, which in turn arises out of double dependence. By double dependence I mean dependence which could not at the time be appreciated even unconsciously by the individual, and which therefore cannot be communicated to an analyst in a patient's analysis. As I have said elsewhere (Chapter 9), the analyst has to reclothe the patient's material, using his or her imagination in so doing.

Summary

By my way of looking at things at the beginning we see a concentration of environmental phenomena in which there crystallizes out a person, a mother, and it is in the mother that the infant begins to appear first as an anatomical and a physiological unit, and then gradually, at about the birth date, becomes a male or a female person. This infant member of 'the nursing couple' develops in his or her own right *in so far as the environment does not fail in its various essential functions*, functions which change in their emphasis and develop in their quality as the growth of the individual proceeds.

Under the most favourable conditions, where continuity is preserved externally and the facilitating environment allows the maturational process to act, the new individual really starts and eventually comes to feel real, and to experience life appropriate to his or her emotional age. This individual can be described and typed, defences can be classified, and value or lack of value in the personality can be noted. In such cases we may find depressive or psycho-neurotic defences or we may find a normality. If we like we may attempt to group individuals according to types, and according to the ways the hereditary elements gather together in individuals in relation to specific environments; and (in maturity) we may go on to take note of the capacity of the individual to take part in the creation and maintenance of the local environment.

All this assumes a good enough beginning, with the true self operative, protected by a false self which is no more than a social manner.

The alternative is psychotic illness, with organization of primitive defences. Here the illness is aetiologically secondary to environmental failure, although the illness shows clinically in a more or less permanent distortion in the personality structure of an individual. In between these two is the antisocial tendency, in

which the environment fails at a later stage, a stage of relative dependence, a stage at which the individual child has the equipment to perceive the fact of an actual deprivation.

In our therapeutic work we may choose to study and isolate the distortion that takes place in the personality structure. Our immediate need, however, is for a classification and a re-evaluation of the environmental factor in so far as this affects in a positive or negative way the maturational development and the integration of the self.

Postscript 1964:

A Note on Mental Breakdown

Some patients have a fear of mental breakdown. It is important for the analyst to keep in mind the following axiom:

Axiom

The breakdown that is feared has already been. What is known as the patient's illness is a system of defences organized relative to this past breakdown.

Breakdown means a failure of defences, and the original breakdown ended when the new defences were organized which constitute the patient's illness pattern. The patient can remember the breakdown only in the special circumstances of a therapeutic setting, and because of ego-growth.

The patient's fear of breakdown has one of its roots in the patient's need to remember the original breakdown. Memory can only come through re-experiencing. Hence the positive use that can be made of a breakdown if its place in the patient's tendency towards self-cure be recognized and used practically.

The original breakdown took place at a stage of dependence of the individual on parental or maternal ego-support. For this reason work is often done in therapeutics on a later version of the breakdown—say a breakdown in the latency period, or even in early adolescence; this later version occurred when the patient had developed ego-autonomy and a capacity to be a person-having-an-illness. Behind such a breakdown there is always, however, a failure of defences belonging to the individual's infancy or very early childhood.

Often, the environmental factor is not a single trauma but a pattern of distorting influences; the opposite, in fact, of the facilitating environment which allows of individual maturation.

12

EGO DISTORTION IN TERMS OF TRUE AND FALSE SELF

(1960)

One recent development in psycho-analysis has been the increasing use of the concept of the False Self. This concept carries with it the idea of a True Self.

History

This concept is not in itself new. It appears in various guises in descriptive psychiatry and notably in certain religions and philosophical systems. Evidently a real clinical state exists which deserves study, and the concept presents psycho-analysis with an aetiological challenge. Psycho-analysis concerns itself with the questions:

(1) How does the False Self arise?
(2) What is its function?
(3) Why is the False Self exaggerated or emphasized in some cases?
(4) Why do some persons not develop a False Self system?
(5) What are the equivalents to the False Self in normal people?
(6) What is there that could be named a True Self?

It would appear to me that the idea of a False Self, which is an idea which our patients give us, can be discerned in the early formulations of Freud. In particular I link what I divide into a True and a False Self with Freud's division of the self into a part that is central and powered by the instincts (or by what Freud called sexuality, pregenital and genital), and a part that is turned outwards and is related to the world.

Personal Contribution

My own contribution to this subject derives from my working at one and the same time

(*a*) as a paediatrician with mothers and infants and
(*b*) as a psycho-analyst whose practice includes a small series of borderline cases treated by analysis, but needing to experience

in the transference a phase (or phases) of serious regression to dependence.

My experiences have led me to recognize that dependent or deeply regressed patients can teach the analyst more about early infancy than can be learned from direct observation of infants, and more than can be learned from contact with mothers who are involved with infants. At the same time, clinical contact with the normal and abnormal experiences of the infant-mother relationship influences the analyst's analytic theory since what happens in the transference (in the regressed phases of certain of his patients) is a form of infant-mother relationship.

I like to compare my position with that of Greenacre, who has also kept in touch with paediatrics while pursuing her practice of psycho-analysis. With her too it seems to be clear that each of the two experiences has influenced her in her assessment of the other experience.

Clinical experience in adult psychiatry can have the effect on a psycho-analyst of placing a gap between his assessment of a clinical state and his understanding of its aetiology. The gap derives from an impossibility of getting a reliable history of early infancy either from a psychotic patient or from the mother, or from more detached observers. Analytic patients who regress to serious dependence in the transference fill in this gap by showing their expectations and their needs in the dependent phases.

Ego-needs and Id-needs

It must be emphasized that in referring to the meeting of infant needs I am not referring to the satisfaction of instincts. In the area that I am examining the instincts are not yet clearly defined as internal to the infant. The instincts can be as much external as can a clap of thunder or a hit. The infant's ego is building up strength and in consequence is getting towards a state in which id-demands will be felt as part of the self, and not as environmental. When this development occurs, then id-satisfaction becomes a very important strengthener of the ego, or of the True Self; but id-excitements can be traumatic when the ego is not yet able to include them, and not yet able to contain the risks involved and the frustrations experienced up to the point when id-satisfaction becomes a fact.

A patient said to me: 'Good management' (ego care) 'such as I have experienced during this hour IS a feed' (id-satisfaction). He could not have said this the other way round, for if I had fed him he would have complied and this would have played into

his False Self defence, or else he would have reacted and rejected my advances, maintaining his integrity by choosing frustration.

Other influences have been important for me, as for instance when periodically I have been asked for a note on a patient who is now under psychiatric care as an adult but who was observed by myself when an infant or small child. Often from my notes I have been able to see that the psychiatric state that now exists was already to be discerned in the infant-mother relationship. (I leave out infant-father relationships in this context because I am referring to early phenomena, those that concern the infant's relationship to the mother, or to the father as another mother. The father at this very early stage has not become significant as a male person.)

Example

The best example I can give is that of a middle-aged woman who had a very successful False Self but who had the feeling all her life that she had not started to exist, and that she had always been looking for a means of getting to her True Self. She still continues with her analysis, which has lasted many years. In the first phase of this research analysis (this lasted two or three years), I found I was dealing with what the patient called her 'Caretaker Self'. This 'Caretaker Self':

(1) found psycho-analysis;
(2) came and sampled analysis, as a kind of elaborate test of the analyst's reliability;
(3) brought her to analysis;
(4) gradually after three years or more handed over its function to the analyst
(this was the time of the depth of the regression, with a few weeks of a very high degree of dependence on the analyst);
(5) hovered round, resuming caretaking at times when the analyst failed (analyst's illness, analyst's holidays, etc.);
(6) its ultimate fate will be discussed later.

From the evolution of this case it was easy for me to see the defensive nature of the False Self. Its defensive function is to hide and protect the True Self, whatever that may be. Immediately it becomes possible to classify False Self organizations:

(1) At one extreme: the False Self sets up as real and it is this that observers tend to think is the real person. In living relationships, work relationships, and friendships, however, the False Self begins to fail. In situations in which what is

expected is a whole person the False Self has some essential lacking. At this extreme the True Self is hidden.

(2) Less extreme: the False Self defends the True Self; the True Self is, however, acknowledged as a potential and is allowed a secret life. Here is the clearest example of clinical illness as an organization with a positive aim, the preservation of the individual in spite of abnormal environmental conditions. This is an extension of the psycho-analytic concept of the value of symptoms to the sick person.

(3) More towards health: The False Self has as its main concern a search for conditions which will make it possible for the True Self to come into its own. If conditions cannot be found then there must be reorganized a new defence against exploitation of the True Self, and if there be doubt then the clinical result is suicide. Suicide in this context is the destruction of the total self in avoidance of annihilation of the True Self. When suicide is the only defence left against betrayal of the True Self, then it becomes the lot of the False Self to organize the suicide. This, of course, involves its own destruction, but at the same time eliminates the need for its continued existence, since its function is the protection of the True Self from insult.

(4) Still further towards health: the False Self is built on identifications (as for example that of the patient mentioned, whose childhood environment and whose actual nannie gave much colour to the False Self organization).

(5) In health: the False Self is represented by the whole organization of the polite and mannered social attitude, a 'not wearing the heart on the sleeve', as might be said. Much has gone to the individual's ability to forgo omnipotence and the primary process in general, the gain being the place in society which can never be attained or maintained by the True Self alone.

So far I have kept within the bounds of clinical description. Even in this limited area recognition of the False Self is important, however. For instance, it is important that patients who are essentially False Personalities shall not be referred to students of psycho-analysis for analysis under a training scheme. The diagnosis of False Personality is here more important than the diagnosis of the patient according to accepted psychiatric classifications. Also in social work, where all types of case must be accepted and kept in treatment, this diagnosis of False Personality is important in the avoidance of extreme frustration associated

with therapeutic failure in spite of seemingly sound social work based on analytic principles. Especially is this diagnosis important in the *selection* of students for training in psycho-analysis or in psychiatric social work, that is to say, in the selection of case-work students of all kinds. The organized False Self is associated with a rigidity of defences which prevents growth during the student period.

The Mind and the False Self

A particular danger arises out of the not infrequent tie-up between the intellectual approach and the False Self. When a False Self becomes organized in an individual who has a high intellectual potential there is a very strong tendency for the mind to become the location of the False Self, and in this case there develops a dissociation between intellectual activity and psycho-somatic existence. (In the healthy individual, it must be assumed, the mind is not something for the individual to exploit in escape from psycho-somatic being. I have developed this theme at some length in 'Mind and its Relation to the Psyche-Soma', 1949c.)

When there has taken place this double abnormality, (i) the False Self organized to hide the True Self, and (ii) an attempt on the part of the individual to solve the personal problem by the use of a fine intellect, a clinical picture results which is peculiar in that it very easily deceives. The world may observe academic success of a high degree, and may find it hard to believe in the very real distress of the individual concerned, who feels 'phoney' the more he or she is successful. When such individuals destroy themselves in one way or another, instead of fulfilling promise, this invariably produces a sense of shock in those who have developed high hopes of the individual.

Aetiology

The main way in which these concepts become of interest to psycho-analysts derives from a study of the way a False Self develops at the beginning, in the infant-mother relationship, and (more important) the way in which a False Self does not become a significant feature in normal development.

The theory relative to this important stage in ontogenetic development belongs to the observation of infant-to-mother (regressed patient-to-analyst) living, and it does not belong to the theory of early mechanisms of ego-defence organized against id-impulse, though of course these two subjects overlap.

To get to a statement of the relevant developmental process it is essential to take into account the mother's behaviour and atti-

tude, because in this field dependence is real, and near absolute. *It is not possible to state what takes place by reference to the infant alone.*

In seeking the aetiology of the False Self we are examining the stage of first object-relationships. At this stage the infant is most of the time unintegrated, and never fully integrated; cohesion of the various sensori-motor elements belongs to the fact that the mother holds the infant, sometimes physically, and all the time figuratively. Periodically the infant's gesture gives expression to a spontaneous impulse; the source of the gesture is the True Self, and the gesture indicates the existence of a potential True Self. We need to examine the way the mother meets this infantile omnipotence revealed in a gesture (or a sensori-motor grouping). I have here linked the idea of a True Self with the spontaneous gesture. Fusion of the motility and erotic elements is in process of becoming a fact at this period of development of the individual.

The Mother's Part

It is necessary to examine the part played by the mother, and in doing so I find it convenient to compare two extremes; by one extreme the mother *is a good-enough mother* and by the other the mother *is not a good-enough mother.* The question will be asked: what is meant by the term 'good-enough'?

The good-enough mother meets the omnipotence of the infant and to some extent makes sense of it. She does this repeatedly. A True Self begins to have life, through the strength given to the infant's weak ego by the mother's implementation of the infant's omnipotent expressions.

The mother who is not good enough is not able to implement the infant's omnipotence, and so she repeatedly fails to meet the infant gesture; instead she substitutes her own gesture which is to be given sense by the compliance of the infant. This compliance on the part of the infant is the earliest stage of the False Self, and belongs to the mother's inability to sense her infant's needs.

It is an essential part of my theory that the True Self does not become a living reality except as a result of the mother's repeated success in meeting the infant's spontaneous gesture or sensory hallucination. (This idea is closely linked with Sechehaye's idea contained in the term 'symbolic realization'. This term has played an important part in modern psycho-analytic theory, but it is not quite accurate since it is the infant's *gesture or hallucination* that is made real, and the capacity of the infant *to use a symbol* is the result.)

There are now two possible lines of development in the scheme

of events according to my formulation. *In the first case* the mother's adaptation is *good enough* and in consequence the infant begins to believe in external reality which appears and behaves as by magic (because of the mother's relatively successful adaptation to the infant's gestures and needs), and which acts in a way that does not clash with the infant's omnipotence. On this basis the infant can gradually abrogate omnipotence. The True Self has a spontaneity, and this has been joined up with the world's events. The infant can now begin to enjoy the *illusion* of omnipotent creating and controlling, and then can gradually come to recognize the illusory element, the fact of playing and imagining. Here is the basis for the symbol which at first is *both* the infant's spontaneity or hallucination, *and also* the external object created and ultimately cathected.

In between the infant and the object is some thing, or some activity or sensation. In so far as this joins the infant to the object (viz. maternal part-object) so far is this the basis of symbol-formation. On the other hand, in so far as this something separates instead of joins, so is its function of leading on to symbol-formation blocked.

In the second case, which belongs more particularly to the subject under discussion, the mother's adaptation to the infant's hallucinations and spontaneous impulses is deficient, *not good enough*. The process that leads to the capacity for symbol-usage does not get started (or else it becomes broken up, with a corresponding withdrawal on the part of the infant from advantages gained).

When the mother's adaptation is not good enough at the start the infant might be expected to die physically, because cathexis of external objects is not initiated. The infant remains isolated. But in practice the infant lives, but lives falsely. The protest against being forced into a false existence can be detected from the earliest stages. The clinical picture is one of general irritability, and of feeding and other function disturbances which may, however, disappear clinically, only to reappear in serious form at a later stage.

In this second case, where the mother cannot adapt well enough, the infant gets seduced into a compliance, and a compliant False Self reacts to environmental demands and the infant seems to accept them. Through this False Self the infant builds up a false set of relationships, and by means of introjections even attains a show of being real, so that the child may grow to be just like mother, nurse, aunt, brother, or whoever at the time dominates the scene. The False Self has one positive and very

important function: to hide the True Self, which it does by compliance with environmental demands.

In the extreme examples of False Self development, the True Self is so well hidden that spontaneity is not a feature in the infant's living experiences. Compliance is then the main feature, with imitation as a speciality. When the degree of the split in the infant's person is not too great there may be some almost personal living through imitation, and it may even be possible for the child to act a special role, that of the True Self *as it would be if it had had existence.*

In this way it is possible to trace the point of origin of the False Self, which can now be seen to be a defence, a defence against that which is unthinkable, the exploitation of the True Self, which would result in its annihilation. (If the True Self ever gets exploited and annihilated this belongs to the life of an infant whose mother was not only 'not good enough' in the sense set out above, but was good and bad in a tantalizingly irregular manner. The mother here has as part of her illness a need to cause and to maintain a muddle in those who are in contact with her. This may appear in a transference situation in which the patient tries to make the analyst mad (Bion, 1959; Searles, 1959). There may be a degree of this which can destroy the last vestiges of an infant's capacity to defend the True Self.)

I have attempted to develop the theme of the part the mother plays in my paper on 'Primary Maternal Preoccupation' (1956a). The assumption made by me in this paper is that, in health, the mother who becomes pregnant gradually achieves a high degree of identification with her infant. This develops during the pregnancy, is at its height at the time of lying in, and it gradually ceases in the weeks and months after the confinement. This healthy thing that happens to mothers has both hypochondriacal and secondary narcissistic implications. This special orientation on the part of the mother to her infant not only depends on her own mental health, but also it is affected by the environment. In the simplest case the man, supported by a social attitude which is itself a development from the man's natural function, deals with external reality for the woman, and so makes it safe and sensible for her to be temporarily in-turned, self-centred. A diagram of this resembles the diagram of an ill paranoid person or family. (One is reminded here of Freud's (1920) description of the living vesicle with its receptive cortical layer. . . .)

The development of this theme does not belong here, but it is important that the function of the mother should be understood. This function is by no means a recent development, belonging to

civilization or to sophistication or to intellectual understanding. No theory is acceptable that does not allow for the fact that mothers have always performed this essential function well enough. This essential maternal function enables the mother to know about her infant's earliest expectations and needs, and makes her personally satisfied in so far as the infant is at ease. It is because of this identification with her infant that she knows how to hold her infant, so that the infant starts by existing and not by reacting. Here is the origin of the True Self which cannot become a reality without the mother's specialized relationship, one which might be described by a common word: devotion.[1]

The True Self

The concept of 'A False Self' needs to be balanced by a formulation of that which could properly be called the True Self. At the earliest stage the True Self is the theoretical position from which come the spontaneous gesture and the personal idea. The spontaneous gesture is the True Self in action. Only the True Self can be creative and only the True Self can feel real. Whereas a True Self feels real, the existence of a False Self results in a feeling unreal or a sense of futility.

The False Self, if successful in its function, hides the True Self, or else finds a way of enabling the True Self to start to live. Such an outcome may be achieved by all manner of means, but we observe most closely those instances in which the sense of things being real or worth while arrives during a treatment. My patient to whose case I have referred has come near the end of a long analysis *to the beginning of her life.* She contains no true experience, she has no past. She starts with fifty years of wasted life, but at last she feels real, and therefore she now wants to live.

The True Self comes from the aliveness of the body tissues and the working of body-functions, including the heart's action and breathing. It is closely linked with the idea of the Primary Process, and is, at the beginning, essentially not reactive to external stimuli, but primary. There is but little point in formulating a True Self idea except for the purpose of trying to understand the False Self, because it does no more than collect together the details of the experience of aliveness.

Gradually the degree of sophistication of the infant becomes such that it is more true to say that the False Self hides the infant's inner reality than to say that it hides the True Self. By this time the infant has an established limiting membrane, has an inside

[1] On account of this I called my series of talks to mothers, 'The Ordinary Devoted Mother and Her Baby' (Winnicott, 1949a).

and an outside, and has become to a considerable extent disentangled from maternal care.

It is important to note that according to the theory being formulated here the concept of an individual inner reality of objects applies to a stage later than does the concept of what is being termed the True Self. The True Self appears as soon as there is any mental organization of the individual at all, and it means little more than the summation of sensori-motor aliveness.

The True Self quickly develops complexity, and relates to external reality by natural processes, by such processes as develop in the individual infant in the course of time. The infant then comes to be able to react to a stimulus without trauma because the stimulus has a counterpart in the individual's inner, psychic reality. The infant then accounts for all stimuli as projections, but this is a stage that is not necessarily achieved, or that is only partially achieved, or it may be reached and lost. This stage having been achieved, the infant is now able to retain the sense of omnipotence even when reacting to environmental factors that the observer can discern as truly external to the infant. All this precedes by years the infant's capacity to allow in intellectual reasoning for the operation of pure chance.

Every new period of living in which the True Self has not been seriously interrupted results in a strengthening of the sense of being real, and with this goes a growing capacity on the part of the infant to tolerate two sets of phenomena: These are:

(1) Breaks in continuity of True Self living. (Here can be seen a way in which the birth process might be traumatic, as for instance when there is delay without unconsciousness.)
(2) Reactive or False Self experiences, related to the environment on a basis of compliance. This becomes the part of the infant which can be (before the first birthday) taught to say 'Ta', or, in other words, can be taught to acknowledge the existence of an environment that is becoming intellectually accepted. Feelings of gratitude may or may not follow.

The Normal Equivalent of the False Self

In this way, by natural processes, the infant develops an ego-organization that is adapted to the environment; but this does not happen automatically and indeed it can only happen if first the True Self (as I call it) has become a living reality, because of the mother's good-enough adaptation to the infant's living needs. There is a compliant aspect to the True Self in healthy living, an ability of the infant to comply and not to be exposed. The ability

to compromise is an achievement. The equivalent of the False Self in normal development is that which can develop in the child into a social manner, something which is adaptable. In health this social manner represents a compromise. At the same time, in health, the compromise ceases to become allowable when the issues become crucial. When this happens the True Self is able to override the compliant self. Clinically this constitutes a recurring problem of adolescence.

Degrees of False Self

If the description of these two extremes and their aetiology is accepted it is not difficult for us to allow in our clinical work for the existence of a low or a high degree of the False Self defence, ranging from the healthy polite aspect of the self to the truly split-off compliant False Self which is mistaken for the whole child. It can easily be seen that sometimes this False Self defence can form the basis for a kind of sublimation, as when a child grows up to be an actor. In regard to actors, there are those who can be themselves and who also can act, whereas there are others who can only act, and who are completely at a loss when not in a role, and when not being appreciated or applauded (acknowledged as existing).

In the healthy individual who has a compliant aspect of the self but who exists and who is a creative and spontaneous being, there is at the same time a capacity for the use of symbols. In other words health here is closely bound up with the capacity of the individual to live in an area that is intermediate between the dream and the reality, that which is called the cultural life. (See 'Transitional Objects and Transitional Phenomena', 1951.) By contrast, where there is a high degree of split between the True Self and the False Self which hides the True Self, there is found a poor capacity for using symbols, and a poverty of cultural living. Instead of cultural pursuits one observes in such persons extreme restlessness, an inability to concentrate, and a need to collect impingements from external reality so that the living-time of the individual can be filled by reactions to these impingements.

Clinical Application

Reference has already been made to the importance of a recognition of the False Self personality when a diagnosis is being made for the purposes of the assessment of a case for treatment, or the assessment of a candidate for psychiatric or social psychiatric work.

Consequences for the Psycho-Analyst

If these considerations prove to have value, then the practising psycho-analyst must be affected in the following ways:

(*a*) In analysis of a False Personality the fact must be recognized that the analyst can only talk to the False Self of the patient about the patient's True Self. It is as if a nurse brings a child, and at first the analyst discusses the child's problem, and the child is not directly contacted. Analysis does not start until the nurse has left the child with the analyst, and the child has become able to remain alone with the analyst and has started to play.

(*b*) At the point of transition, when the analyst begins to get into contact with the patient's True Self, there must be a period of extreme dependence. Often this is missed in analytic practice. The patient has an illness, or in some other way gives the analyst a chance to take over the False Self (nursemaid) function, but the analyst at that point fails to see what is happening, and in consequence it is others who care for the patient and on whom the patient becomes dependent in a period of disguised regression to dependence, and the opportunity is missed.

(*c*) Analysts who are not prepared to go and meet the heavy needs of patients who become dependent in this way must be careful so to choose their cases that they do not include False Self types.

In psycho-analytic work it is possible to see analyses going on indefinitely because they are done on the basis of work with the False Self. In one case, a man patient who had had a considerable amount of analysis before coming to me, my work really started with him when I made it clear to him that I recognized his non-existence. He made the remark that over the years all the good work done with him had been futile because it had been done on the basis that he existed, whereas he had only existed falsely. When I had said that I recognized his non-existence he felt that he had been communicated with for the first time. What he meant was that his True Self that had been hidden away from infancy had now been in communication with his analyst in the only way which was not dangerous. This is typical of the way in which this concept affects psycho-analytic work.

I have referred to some other aspects of this clinical problem. For instance, in 'Withdrawal and Regression' (1954a) I traced in the treatment of a man the evolution in the transference of my

contact with (his version of) a False Self, through my first contact with his True Self, to an analysis of a straightforward kind. In this case withdrawal had to be converted into regression as described in the paper.

A principle might be enunciated, that in the False Self area of our analytic practice we find we make more headway by recognition of the patient's non-existence than by a long-continued working with the patient on the basis of ego-defence mechanisms. The patient's False Self can collaborate indefinitely with the analyst in the analysis of defences, being so to speak on the analyst's side in the game. This unrewarding work is only cut short profitably when the analyst can point to and specify an absence of some essential feature: 'You have no mouth', 'You have not started to exist yet', 'Physically you are a man, but you do not know from experience anything about masculinity', and so on. These recognitions of important fact, made clear at the right moments, pave the way for communication with the True Self. A patient who had had much futile analysis on the basis of a False Self, co-operating vigorously with an analyst who thought this was his whole self, said to me: 'The only time I felt hope was when you told me that you could see no hope, and you continued with the analysis.'

On the basis of this one could say that the False Self (like the multiple projections at later stages of development) deceives the analyst if the latter fails to notice that, regarded as a whole functioning person, the False Self, however well set up, lacks something, and that something is the essential central element of creative originality.

Many other aspects of the application of this concept will be described in the course of time, and it may be that in some ways the concept itself will need to be modified. My object in giving an account of this part of my work (which links with the work of other analysts) is that I hold the view that this modern concept of the False Self hiding the True Self *along with the theory of its aetiology* is able to have an important effect on psycho-analytic work. As far as I can see it involves no important change in basic theory.

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STRING: A TECHNIQUE OF COMMUNICATION[1]

(1960)

A boy aged seven years was brought to the Psychology Department of the Paddington Green Children's Hospital by his mother and father in March 1955. The other two members of the family also came: an M.D. girl aged ten, attending an E.S.N. school, and a rather normal small girl aged four. The case was referred by the family doctor because of a series of symptoms indicating a character disorder in the boy. For the purposes of this description all details that are not immediately relevant to the main theme of this paper are omitted. An intelligence test gave this boy an I.Q. of 108.

I first saw the parents in a long interview in which they gave a clear picture of the boy's development and of the distortions in his development. They left out one important detail, however, which emerged in the interview with the boy.

It was not difficult to see that the mother was a depressive person, and she reported that she had been hospitalized on account of depression. From the parents' account I was able to note that the mother cared for the boy until the sister was born when he was 3 years 3 months. This was the first separation of importance, the next being at 3 years 11 months when the mother had an operation. When the boy was 4 years 9 months the mother went into a mental hospital for two months, and during this time he was well cared for by his mother's sister. By this time everyone looking after this boy agreed that he was difficult, although showing very good features. He was liable to change suddenly and to frighten people by saying, for instance, that he would cut his mother's sister into little pieces. He developed many curious symptoms such as a compulsion to lick things and people; he made compulsive throat noises; often he refused to pass a motion and then made a mess. He was obviously anxious about his elder sister's mental defect, but the distortion of his development appears to have started before this factor became significant.

[1] First published in the *Journal of Child Psychology and Psychiatry*, **1**, pp. 49–52.

After this interview with the parents I saw the boy in a personal interview. There were present two psychiatric social workers and two visitors. The boy did not immediately give an abnormal impression and he quickly entered into a squiggle game with me. (In this squiggle game I make some kind of an impulsive line-drawing and invite the child whom I am interviewing to turn it into something, and then he makes a squiggle for me to turn into something in my turn.)

The squiggle game in this particular case led to a curious result. The boy's laziness immediately became evident, and also nearly everything I did was translated by him into something associated with string. Among his ten drawings there appeared the following:

lasso, whip, crop,
a yo-yo string,
a string in a knot,
another crop,
another whip.

After this interview with the boy I had a second one with the parents, and asked them about the boy's preoccupation with string. They said they were glad that I had brought up this subject, but they had not mentioned it because they were not sure of its significance. They said that the boy had become obsessed with everything to do with string, and in fact whenever they went into a room they were liable to find that he had joined together chairs and tables; and they might find a cushion, for instance, with a string joining it to the fireplace. They said that the boy's preoccupation with string was gradually developing a new feature, one which had worried them instead of causing them ordinary concern. He had recently tied a string round his sister's neck (the sister whose birth provided the first separation of this boy from his mother).

In this particular kind of interview I knew I had limited opportunity for action: it would not be possible to see these parents or the boy more frequently than once in six months, as the family lived in the country. I therefore took action in the following way. I explained to the mother that this boy was dealing with a fear of separation, attempting to deny separation by his use of string, as one would deny separation from a friend by using the telephone. She was sceptical, but I told her that should she come round to finding some sense in what I was saying I would like her to open up the matter with the boy at some convenient time, letting him know what I had said, and then

developing the theme of separation according to the boy's response.

I heard no more from these people until they came to see me about six months later. The mother did not report to me what she had done, but I asked her and she was able to tell me what had taken place soon after the visit to me. She had felt that what I had said was silly, but one evening she had opened the subject with the boy and found him to be eager to talk about his relation to her and his fear of a lack of contact with her. She went over all the separations she could think of with him with his help, and she soon became convinced that what I had said was right, because of his responses. Moreover, from the moment that she had this conversation with him the string play ceased. There was no more joining of objects in the old way. She had many other conversations with the boy about his feeling of separateness from her, and she made the very important comment that she felt the most important separation to have been his loss of her when she was seriously depressed: it was not just her going away, she said, but her lack of contact with him because of her complete preoccupation with other matters.

At a later interview the mother told me that a year after she had her first talk with the boy there was a return to playing with string and to joining together objects in the house. She was in fact due to go into hospital for an operation, and she said to him: 'I can see from your playing with string that you are worried about my going away, but this time I shall only be away a few days, and I am having an operation which is not serious.' After this conversation the new phase of playing with string ceased.

I have kept in touch with this family and have helped with various details in the boy's schooling and other matters. Now, four years after the original interview, the father reports a new phase of string preoccupation, associated with a fresh depression in the mother. This phase lasted two months, and cleared up when the whole family went on holiday, and when at the same time there was an improvement in the home situation (the father having found work after a period of unemployment). Associated with this was an improvement in the mother's state. The father gave one further interesting detail relevant to the subject under discussion. During this recent phase the boy had acted out something with rope which the father felt to be significant, because it showed how intimately all these things were connected with the mother's morbid anxiety. He came home one day and found the boy hanging upside down on a rope. He was

quite limp and acting very well as if dead. The father realized he must take no notice, and he hung around the garden doing odd jobs for half an hour, after which the boy got bored and stopped the game. This was a big test of the father's lack of anxiety. On the following day, however, the boy did the same thing from a tree which could easily be seen from the kitchen window. The mother rushed out severely shocked and certain that he had hanged himself.

The following additional detail might be of value in the understanding of the case. Although this boy, who is now eleven, is developing along 'tough-guy' lines, he is very self-conscious and easily goes red in the neck. He had a number of teddy bears which to him are children. No one dares say that they are toys. He is loyal to them, expends a great deal of affection over them, and makes trousers for them which involves careful sewing. His father says that he seems to get a sense of security from his family, which he mothers in this way. If visitors come he quickly puts them all into his sister's bed, because no one outside the family must know that he has this family. Along with this is a reluctance to defaecate, or a tendency to save up his faeces. It is not difficult to guess, therefore, that he has a maternal identification based on his own insecurity in relation to his mother, and that this could develop into homosexuality. In the same way the preoccupation with string could develop into a perversion.

Comment

The following comment seems to be appropriate.

(1) String can be looked upon as an extension of all other techniques of communication. String joins just as it also helps in the wrapping up of objects and in the holding of unintegrated material. In this respect string has a symbolic meaning for everyone; an exaggeration of the use of string can easily belong to the beginnings of a sense of insecurity or the idea of a lack of communication. In this particular case it is possible to detect abnormality creeping into the boy's use of string, and it is important to find a way of stating the change which might lead to its use becoming perverted.

It would seem possible to arrive at such a statement if one takes into consideration the fact that the function of the string is changing from a joining into a *denial of separation.* As a denial of separation spring becomes a thing in itself, something which has dangerous properties and has to be mastered. In this case the mother seems to have been able to deal with the boy's use

of spring just before it was too late, when the use of it still contained hope. When hope is absent and string represents a denial of separation, then a much more complex state of affairs has arisen—one which becomes difficult to cure, because of the secondary gains which arise out of the skill that develops whenever an object has to be handled in order to be mastered.

This case therefore presents special interest if it makes possible the observation of the development of a perversion.

(2) It is also possible to see from this material the use that can be made of parents. When parents can be used they can work with great economy, especially if the fact is kept in mind that there will never be enough psychotherapists to treat all those who are in need of treatment. Here was a good family that had been through a difficult time because of the father's unemployment; that had been able to take full responsibility for a backward girl in spite of the tremendous drawbacks, socially and within the family, that this entails; and that had survived the bad phases in the mother's depressive illness, including one phase of hospitalization. There must be a great deal of strength in such a family, and it was on the basis of this assumption that the decision was made to invite these parents to undertake the therapy of their own child. In doing this they learned a great deal themselves, but they did need to be informed about what they were doing. They also needed their success to be appreciated and for the whole process to be verbalized. The fact that they have seen their boy through an illness has given the parents confidence with regard to their ability to manage the other difficulties which arise from time to time.

Summary

A case has been briefly described in order to illustrate a boy's compulsion to use string, at first in an attempt to communicate symbolically with his mother in spite of her withdrawal during depressive phases, and then as a denial of the separation. As a symbol of the denial of separation, string became a thing that was frightening and that had to be mastered, and its use then became perverted. In this case the mother herself did the psychotherapy, her task being explained to her by the psychiatrist.

COUNTER-TRANSFERENCE[1]

(1960)

What I want to say can be briefly stated.

I think that the use of this word counter-transference should now be brought back to its original use. We can use words as we like, especially artificial words like counter-transference. A word like 'self' naturally knows more than we do; it uses us, and can command us. But counter-transference is a term that we can enslave, and a perusal of the literature makes me think that it is in danger of losing its identity.

There is now quite a literature around the term, and I have tried to study it. In my paper 'Hate in the Counter-transference' (1947) (which is chiefly about hate), I said that one use of the word counter-transference would be to describe 'abnormality in counter-transference feelings, and set relationships and identifications that are under repression in the analyst. The comment on this is that the analyst needs more analysis. . . .'

For the purposes of that paper I then gave two other possible meanings.

A discussion based on the failures of the analysts' own analyses must be futile. In a sense, this ends the debate.

The meaning of the word counter-transference can be extended, however, and I think we have all agreed to extend it a little so that we may take this opportunity to look at our work afresh. I shall return, however, to this idea that I have already expressed. Before I proceed I must go back to a remark made by Michael Fordham at the beginning of his paper, in which he quotes Jung as protesting against the idea that transference is the product of psycho-analytic technique, emphasizing that it is a general transpersonal or social phenomenon. Apart from the fact that I do not know what 'transpersonal' means, I think that confusion could arise here by a distortion of the use of the term transference as I think Freud introduced it. The characteristic of psycho-analytic technique is this use of transference and of the

[1] Presented in the second part of a Symposium on Counter-Transference held by the Medical Section of the British Psychological Society, London, 25 November 1959, and first published in the *British Journal of Medical Psychology*, **33**, pp. 17–21.

transference neurosis. Transference is not just a matter of rapport, or of relationships. It concerns the way in which a highly subjective phenomenon repeatedly turns up in an analysis. Psycho-analysis very much consists in the arranging of conditions for the development of these phenomena, and in the interpretation of these phenomena at the right moment. The interpretation relates the specific transference phenomenon to a bit of the patient's psychic reality, and this in some cases means at the same time relating it to a bit of the patient's past living.

In a typical example, a patient is gradually working round to suspicion and hate in the relation to the analyst, which can be seen to have a correlation with the danger of meeting another patient, or with the breaks due to week-ends and holidays. In the course of time an interpretation makes sense of all this in terms not of the present but of the dynamic structure of the patient's personality. Following this work the patient loses the specific transference neurosis and begins to boil up for another. (Often the work is not done in such a clear way, but for teaching purposes this might be a fair description of a basic principle.)

Michael Fordham (1960) gave a good example of this in the patient who asked questions. Eventually she said: 'You are like my father, you never answer questions.' Often a patient will have given clues so that the analyst may interpret fruitfully, but here a little bit (but an important bit) of the interpretation was arrived at by the patient, and no doubt the analyst was then able to weigh in with a more complete interpretation.

It is necessary for me to take up time in this way because if we do not agree about the term transference we must not start discussing counter-transference.

Incidentally, may I remind Dr Fordham that some of the terms he uses are not of any value to me because they belong to the jargon of Jungian conversation. He in turn can tell me which of my words are useless to him. I refer to: transpersonal, transpersonal unconscious, transpersonal analytic ideal, archetypal, the contra-sexual components of the psyche, the animus and anima, animus-anima conjunction.

I cannot be communicated with in this language. For some in this hall these are household words, and for the rest they have no precise meaning.

We must also be careful over the use of words that are used in different ways by various groups of workers: ego, unconscious, illusory, syntonic (react syntonically), analysis, etc.

I can now return to the subject of transference-counter-transference phenomena and examine what happens in pro-

fessional work generally. Professional work is quite different from ordinary life, is it not?

All this started up with Hippocrates. He perhaps founded the professional attitude. The medical oath gives a picture of a man or woman who is an idealized version of the ordinary man or woman in the street. Yet *that is how we are* when professionally engaged. Included in the oath is the promise that we do not commit adultery with a patient. Here is a full recognition of one aspect of the transference, the patient's need to idealize the doctor, and to fall in love with him, to dream.

Freud allowed for the development of a full range of subjective phenomena in the professional relationship; the analyst's own analysis was in effect a recognition that the analyst is *under strain in maintaining a professional attitude.* It is on purpose that I use this wording. I am not saying that the analyst's analysis is to free him from neurosis; it is to increase the stability of character and the maturity of the personality of the worker, this being the basis of his or her professional work and of our ability to maintain a professional relationship.

A professional attitude may, of course, be built up on a basis of defences and inhibitions and obsessional orderliness, and I suggest that it is here that the psychotherapist is particularly under strain, because *any structuring of his ego-defences lessens his ability to meet the new situation.* The psychotherapist (analyst, or analytical psychologist) must remain vulnerable, and yet retain his professional role in his actual working hours. I guess that the well-behaving professional analyst is easier to come by than the analyst who (while behaving well) retains the vulnerability that belongs to a flexible defence organization. (Fordham refers to this same idea in his own language.)

There is a much fuller use of transference phenomena in psycho-analysis than in social work, for instance. This gives a therapeutic advantage to the analyst over the social worker, but it is necessary to remember the advantages that remain with the more general case-worker who, working in with the patient's ego-functions, is in a better position to relate the individual's ego-needs to social provision. As analysts we are often hampered in this which is not our function.

In analysis the transference neurosis is characteristically id-derived. In social work a man may say to the worker, 'You remind me of my mother.' Nothing need be done about this, except for the worker to believe in it. In analysis the analyst will be given the clues so that he can interpret not only the transference of feelings from mother to analyst, but also the unconscious in-

stinctual elements that underlie this, and the conflicts that are aroused, and the defences that organize. In this way the unconscious begins to have a conscious equivalent and to become a living process involving people, and to be a phenomenon that is acceptable to the patient.

What the patient meets is surely the professional attitude of the analyst, not the unreliable men and women we happen to be in private life.

I want to make this clear observation first, although later I shall modify what I am now saying.

I want to state that the working analyst is in a special state, that is, *his attitude is professional.* The work is done in a professional setting. In this setting we assume a freedom of the analyst from personality and character disorder of such a kind or degree that the professional relationship cannot be maintained, or can only be maintained at great cost involving excessive defences.

The professional attitude is rather like symbolism, in that it assumes a *distance between analyst and patient.* The symbol is in a gap between the subjective object and the object that is perceived objectively.

It will be seen that here I am disagreeing with a statement of Fordham's although a little later I shall agree with him. The statement I am disagreeing with is the following: 'He [Jung] compares the analytic relation to a chemical interaction, and continues that treatment can "by no device . . . be anything but the product of mutual influence, in which the whole being of the doctor as well as the patient plays a part".' Later he is very emphatic that it is futile for the analyst to erect defences of a professional kind against the influence of the patient, and continues: 'By doing so he only denies himself the use of a highly important organ of information.'

I would rather be remembered as maintaining that in between the patient and the analyst is the analyst's professional attitude, his technique, *the work he does with his mind.*

Now I say this without fear because I am not an intellectual and in fact I personally do my work very much from the body-ego, so to speak. But I think of myself in my analytic work working with easy but conscious mental effort. Ideas and feelings come to mind, but these are well examined and sifted before an interpretation is made. This is not to say that feelings are not involved. On the one hand I may have stomach ache but this does not usually affect my interpretations; and on the other hand I may have been somewhat stimulated erotically or aggressively by an idea given by the patient, but again this fact does not

usually affect my interpretative work, what I say, how I say it or when I say it.

The analyst is objective and consistent, for the hour, and he is not a rescuer, a teacher, an ally, or a moralist. The important effect of the analyst's own analysis in this connexion is that it has strengthened his own ego so that he can remain *professionally* involved, and this without too much strain.

In so far as all this is true the meaning of the word counter-transference can only be the neurotic features *which spoil the professional attitude* and disturb the course of the analytic process as determined by the patient.

In my opinion this holds except in so far as the diagnosis of the patient is of a certain kind, and I now want to describe the kinds of diagnosis which to my mind alter the whole problem and make me wish to agree with the statement that I have just disagreed with. The subject under discussion is now: *the role of the analyst*; and this role must vary according to the diagnosis of the patient. Neither speaker had time to refer more than briefly to the matter of diagnosis (although Fordham quoted Jung: 'It is clear, however, that he is sure the patient can have very drastic effects on the analyst and that this can induce pathological manifestations in him. He states that this is particularly the case when cases of borderline schizophrenia are being treated; and Jung developes this theme in an interesting way).

I am now, therefore, speaking from a different position, and the change comes from the fact that I now refer to the management and treatment of borderline cases for which the word psychotic is more appropriate than the word neurotic. But the vast majority of people who may come to us for psycho-analysis are not psychotic and students must be first taught the analysis of non-psychotic cases.

You might expect me to use words like psycho-neurosis, psychosis, or hysteria, affective disorder and schizophrenia, but I shall not do so in classifying cases for our purposes here.

Two types of case seem to me to completely alter the therapist's professional attitude. One is the patient who has *an antisocial tendency*, and the other is the patient *who needs a regression*. The first, the patient with more or less antisocial tendency, is permanently reacting to a deprivation. The therapist is compelled by the patient's illness, or by the hopeful half of the patient's illness, to correct and to go on correcting the failure of ego-support which altered the course of the patient's life. The only thing the therapist can do, apart from getting caught up, is to use what happens in an attempt to get down to a precise statement of the original

deprivation or deprivations, as perceived and felt by the patient as a child. This may or may not involve work with the patient's unconscious. A therapist wholly engaged in work with patients who display an antisocial tendency would not be in a good position to understand the psycho-analytic technique or the operation of the transference, or the interpretation of the transference neurosis. We try to avoid giving our psycho-analytic students antisocial cases, precisely because we cannot teach psycho-analysis on these cases. They are better dealt with in other ways, though psycho-analysis can sometimes be usefully added. I shall leave aside further consideration of the antisocial tendency.

In the other type of patient to which I refer a regression will be needed. If a significant change is to be brought about the patient will need to pass through a phase of infantile dependence. Here again psycho-analysis cannot be taught, though it can be practised in modified form. The difficulty here is in diagnosis, in the spotting of the falseness of the false personality which hides the immature true self. If the hidden true self is to come into its own in such a case the patient will break down as part of the treatment, and the analyst will need to be able to play the part of mother to the patient's infant. This means giving ego-support in a big way. The analyst will need to remain orientated to external reality while in fact being identified with the patient, even merged in with the patient. The patient must become highly dependent, even absolutely dependent, and these words are true even when there is a healthy part of the personality that acts all along as an ally of the analyst and in fact tells the analyst how to behave.

You will note that I am now using phrases that are in line with phrases used by Fordham.

Now here again it can be said that analysts who work chiefly with patients who become very fully dependent in this way can fail to understand and learn the psycho-analytic technique which is based on work with the vast majority of patients, those whose own infantile dependence was successfully managed by their own mothers and fathers. (I cannot too strongly emphasize the fact that most people, if analysed, do need the classical psycho-analytic technique, with the analyst's professional attitude in between the patient and the analyst.)

Per contra, the classical analyst, the one who has learned his job and who is confident in his ability to deal with the transference neurosis as it develops and repeatedly redevelops, has a great deal to learn from those who care for and who attempt to do

psycho-therapy of the patients who need to go through the stages of emotional development that properly belong to infancy.

From this changed position, therefore, with the patient diagnosed as psychotic or schizophrenic, and the transference dominated by the patient's need to regress to infantile dependence, I find I am able to join up with a whole lot of Dr Fordham's observations, which, however, I think he did not properly link with the classification of the patients because he had not time.

The borderline psychotic gradually breaks through the barriers that I have called the analyst's technique and professional attitude, and forces a direct relationship of a primitive kind, even to the extent of merging. This is done in a gradual and orderly manner, and recovery is correspondingly orderly, except where it is part of the illness that chaos must reign supreme both without and within.

In the training of psycho-analysts and the like we must not place the students in the position of being related to the primitive needs of psychotic patients, because few will be able to stand it, and few will be able to learn anything from the experience. On the other hand, in a properly organized psycho-analytic practice there is room for some patients who force their way across the professional borderline, and who make these special tests and demands which we seem to be including under the term counter-transference in this discussion. I could take up the subject of the analyst's responses. In fact I find it difficult to miss this opportunity for discussing all kinds of things that I have experienced and which link up with ideas put forward by Dr Fordham. For instance, I got hit by a patient. What I said is not for publication. It was not an interpretation but a reaction to an event. The patient came across the professional white line and got a little bit of the real me, and I think it felt real to her. But a reaction is not counter-transference.

Would it not be better at this point to *let the term counter-transference revert to its meaning* of that which we hope to eliminate by selection and analysis and the training of analysts? This would leave us free to discuss the many interesting things that analysts can do with psychotic patients who are temporarily regressed and dependent for which we could use Margaret Little's term: the analyst's total response to the patient's needs. Under this or a similar title there is much to be said about the use that the analyst can make of his or her own conscious and unconscious reactions to the impact of the psychotic patient or the psychotic part of the patient on his or her self, and the effect of this on the analyst's professional attitude. I am one of those who have already

written a little and said much on this subject which interests Jungians and Freudians alike. This could form and must indeed form a basis for future discussions, but I think that only muddle can come from stretching to cover all this the word which is in the title of this symposium: counter-transference.

15

THE AIMS OF PSYCHO-ANALYTICAL TREATMENT[1]

(1962)

In doing psycho-analysis I aim at:

Keeping alive
Keeping well
Keeping awake

I aim at being myself and behaving myself.

Having begun an analysis I expect to continue with it, to survive it, and to end it.

I enjoy myself doing analysis and I always look forward to the end of each analysis. Analysis for analysis' sake has no meaning for me. I do analysis because that is what the patient needs to have done and to have done with. If the patient does not need analysis then I do something else.

In analysis one asks: how *much* can one be allowed to do? And, by contrast, in my clinic the motto is: how *little* need be done?

But these are surface matters. What are the deeper aims? What does one do in the professional setting that is so carefully prepared and maintained?

I do adapt quite a little to individual expectations at the very beginning. It is unhuman not to do so. Yet I am all the time manœuvring into the position for standard analysis. What I must try to state is the meaning for me of the term *standard analysis.*

For me this means communicating with the patient from the position in which the transference neurosis (or psychosis) puts me. In this position I have some of the characteristics of a transitional phenomenon, since although I represent the reality principle, and it is I who must keep an eye on the clock, I am nevertheless a subjective object for the patient.

Most of what I do is of the nature of a verbalization of that which the patient brings for me to use today. I make interpretations for two reasons:

[1] Presented to the British Psycho-Analytical Society, 7 March 1962.

(1) If I make none the patient gets the impression that I understand everything. In other words, I retain some outside quality by not being quite on the mark—or even by being wrong.

(2) Verbalization at exactly the right moment mobilizes intellectual forces. It is only a bad thing to mobilize the intellectual processes when these have become seriously dissociated from psycho-somatic being. My interpretations are economical, I hope. One interpretation per session satisfies me if it has referred to the material produced by the patient's unconscious co-operation. I say one thing, or say one thing in two or three parts. I never use long sentences unless I am very tired. If I am near exhaustion point I begin teaching. Moreover, in my view an interpretation containing the word 'moreover' is a teaching session.

The stuff of the secondary process is applied to the stuff of the primary process, as a contribution to growth and integration.

What does the patient bring to me today? This depends on unconscious co-operation which is set up at the time of the first mutative interpretation, or earlier. It is axiomatic that the work of the analysis is done by the patient, and that this is called unconscious co-operation. It includes such things as dreaming, the remembering of dreams and the reporting of them in a useful way.

Unconscious co-operation is the same as resistance, but the latter belongs to a negative transference element. The analysis of resistance releases the co-operation which belongs to positive transference elements.

Although psycho-analysis may be infinitely complex, a few simple things may be said about the work I do, and one is that I expect to find a tendency towards ambivalence in the transference and away from more primitive mechanisms of splitting, introjection and projection, object retaliation, disintegration, etc. I know that these primitive mechanisms are universal and that they have positive value, but they are defences in so far as they weaken the direct tie to the object through instinct, and through love and hate. At the end of endless ramifications in terms of hypochondriacal fantasy and persecutory delusion a patient has a dream which says: I eat you. Here is stark simplicity like that of the Oedipus complex.

Stark simplicity is only possible as a bonus on top of the ego-strengthening that analysis brings about. I would like to make special reference to this but first I must refer to the fact that in

many cases the analyst displaces environmental influences that are pathological, and we gain insight of the kind that enables us to know when we have become modern representatives of the parent figures of the patient's childhood and infancy, and when by contrast we are displacing such figures.

In so far as we come through this, we see ourselves affecting the patient's ego in three phases:

(*a*) We expect a kind of ego-strength in the early stages of an analysis, because of the ego-support that we give simply by doing standard analysis and by doing it well. This corresponds to the ego-support of the mother which (in my theorizing) makes the infant ego strong if and only if the mother is able to play her special part at this time. This is temporary and belongs to a special phase.

(*b*) Then follows a long phase in which the patient's confidence in the analytic process brings about all kinds of experimenting (on the part of the patient) in terms of ego independence.

(*c*) In the third phase the now independent ego of the patient begins to show and to assert its own individual characteristics, and the patient begins to take for granted a feeling of existing in his or her own right.

It is this ego-integration that particularly concerns me, and gives me pleasure (though it must not be for my pleasure that it takes place.) It is very satisfactory to watch the patient's growing ability to gather all things into the area of personal omnipotence, even including the genuine traumata.

Ego-strength results in a clinical change in the direction of a loosening up of the defences which become more economically employed and deployed, with the result that the individual feels no longer trapped in an illness, but feels free, even if not free from symptoms. In short, we see growth and emotional development that had become held up in the original situation.

What about modified analysis?

I find myself working as a psycho-analyst rather than doing standard analysis when I meet certain conditions that I have learned to recognize.

(*a*) Where fear of madness dominates the scene.

(*b*) Where a false self has become successful, and a façade of success and even brilliance will be destroyed at some phase if analysis is to succeed.

(*c*) Where in a patient an antisocial tendency, either in the form of aggression or of stealing or of both, is the legacy of a deprivation.

(*d*) Where there is no cultural life—only an inner psychic reality and a relationship to external reality—the two being relatively un-linked.

(*e*) Where an ill parental figure dominates the scene.

These and many other illness-patterns make me sit up. The essential thing is that I do base my work on diagnosis. I continue to make a diagnosis of the individual and a social diagnosis as I go along, and I do definitely work according to diagnosis. In this sense I do psycho-analysis when the diagnosis is that this individual, in his or her environment, wants psycho-analysis. I might even try to set going an unconscious co-operation, when conscious wish for analysis is absent. But by and large, analysis is for those who want it, need it, and can take it.

When I am faced with the wrong kind of case I change over into being a psycho-analyst who is meeting the needs, or trying to meet the needs, of that special case. I believe this non-analytic work can usually be best done by an analyst who is well versed in the standard psycho-analytic technique.

Finally, I would like to say this:

I have based my statement on the assumption that all analysts are alike in so far as they are analysts. But analysts are not alike. I am not like what I was twenty or thirty years ago. Some analysts undoubtedly work best in the simplest and most dynamic area where the conflict between love and hate, with all its ramifications in conscious and unconscious fantasy, constitutes the main problem. Other analysts work as well or better when they are able to deal with more primitive mental mechanisms in the transference neurosis or transference psychosis. In this way by interpreting part object retaliations, projections and introjections, hypochondriacal and paranoid anxieties, attacks on linkages, thinking disturbances, etc., etc., they extend the field of operation and the range of the cases they can tackle. This is research analysis, and the danger is only that the patient's needs in terms of infantile dependence may be lost in the course of the analyst's performance. Naturally as we come to gain confidence in the standard technique through our use of it in suitable cases we like to feel that we can tackle the borderline case without deviating, and I see no reason why the attempt should not be made, especially as the diagnosis may alter in our favour as the result of our work.

In my opinion our aims in the practice of the standard technique are not altered if it happens that we interpret mental mechanisms which belong to the psychotic types of disorder and to primitive stages in the emotional stages of the individual. If

our aim continues to be to verbalize the nascent conscious in terms of the transference, then we are practising analysis; if not, then we are analysts practising something else that we deem to be appropriate to the occasion. And why not?

16

A PERSONAL VIEW OF THE KLEINIAN CONTRIBUTION[1]

(1962)

In the course of your explorations outside Freud's own writings you will already have come across other important names, and you will have met analysts who have contributed in an original way, and whose contributions have been found generally acceptable. For instance, you will have met Anna Freud, who had a unique position in her father's life during the last two decades, and who cared for him with fortitude when he was ill, and you will be familiar at least with her classic summary of psychoanalytic theory in her *Ego and the Mechanisms of Defence* (1936). In any case, Anna Freud has had an immense influence on the way psycho-analysis has developed in the United States, and her stimulating interest in what others are doing has been responsible for much research that is published under other names.

Now Anna Freud was not so important in England as she has been in the United States, simply because of the very great developments that took place in London in the twenty years after the end of World War I, before Miss Freud came over with her father, refugees from Nazi persecution. It was during this period that my own psycho-analytic growth was making root and stem, and it might interest you therefore to hear from me something of the soil in which I had become planted.

You see, there developed a Melanie Klein–Anna Freud controversy, and this has not yet resolved itself. But this was not important for me in my early and formative years, and it is only important to me now in so far as it hampers free thought. In fact Melanie Klein and Anna Freud had a relationship in the Vienna days but this had no meaning for me.

From my point of view psycho-analysis in England was an edifice whose foundation was Ernest Jones. If any man earned my gratitude it was Ernest Jones, and it was Jones to whom I went when I found I needed help in 1923. He put me in touch with James Strachey, to whom I went for analysis for ten years,

[1] A talk given to the Candidates of the Los Angeles Psychoanalytic Society, 3 October 1962.

but I always knew that it was because of Jones that there was a Strachey and a British Psycho-Analytical Society for me to use.

So I came to psycho-analysis ignorant of personality clashes between the various analysts, and only too pleased to get effective help for the difficulties that were mine.

I was starting up as consultant paediatrician at that time, and you can imagine how exciting it was to be taking innumerable case histories and to be getting from uninstructed hospital-class parents all the confirmation that anyone could need for the psycho-analytic theories that were beginning to have meaning for me through my own analysis. At that time no other analyst was also a paediatrician, and so for two or three decades I was an isolated phenomenon.

I mention these facts because by being a paediatrician with a knack for getting mothers to tell me about their children and about the early history of their children's disorders, I was soon in the position of being astounded both by the insight psycho-analysis gave into the lives of children and by a certain deficiency in psycho-analytic theory which I will describe. At that time, in the 1920s, everything had the Oedipus complex at its core. The analysis of the psycho-neuroses led the analyst over and over again to the anxieties belonging to the instinctual life at the 4–5-year period in the child's relationship to the two parents. Earlier difficulties that came to light were treated in analyses as regressions to pregenital fixation points, but the dynamics came from conflict at the full-blown genital Oedipus complex of the toddler or late toddler age, that is just before the passing of the Oedipus complex and the onset of the latency period. Now, innumerable case histories showed me that the children who became disturbed, whether psycho-neurotic, psychotic, psycho-somatic or antisocial, showed difficulties in their emotional development in infancy, even as babies. Paranoid hypersensitive children could even have started to be in that pattern in the first weeks or even days of life. Something was wrong somewhere. When I came to treat children by psycho-analysis I was able to confirm the origin of psycho-neurosis in the Oedipus complex, and yet I knew that troubles started earlier.

I gave many tentative and frightened papers to colleagues from the mid-twenties onwards pointing out these facts, and eventually my point of view boiled up into a paper (1936) which I called 'Appetite and Emotional Disorder'. In this I gave samples of the case histories that had to be reconciled somehow with the theory of the Oedipus complex as the point of origin of individual conflicts. Babies could be emotionally ill.

It was an important moment in my life when my analyst broke into his analysis of me and told me about Melanie Klein. He had heard about my careful history-taking and about my trying to apply what I got in my own analysis to the cases of children brought to me for every kind of paediatric disorder. I especially investigated the cases of children brought for nightmares. Strachey said: 'If you are applying psycho-analytic theory to children you should meet Melanie Klein. She has been enticed over to England by Jones to do the analysis of someone special to Jones; she is saying some things that may or may not be true, and you must find out for yourself for you will not get what Melanie Klein teaches in my analysis of you.'

So I went to hear and then to see Melanie Klein, and I found an analyst who had a great deal to say about the anxieties that belong to infancy, and I settled down to working with the benefit of her help. I took her a case written up in great detail, and she had the goodness to read it right through, and on the basis of this one pre-Klein analysis that I did on the basis of my own Strachey analysis I went on to try to learn some of the immense amount that I found she knew already.

This was difficult for me, because overnight I had changed from being a pioneer into being a student with a pioneer teacher. Melanie Klein was a generous teacher, and I counted myself lucky. I remember on one occasion going to her for a supervision, and of a whole week's work I could remember nothing at all. She simply responded by telling me of a case of her own.

I now learned psycho-analysis from Melanie Klein, and I found other teachers comparatively rigid. For one thing, she had an amazing memory. On Saturday evening, if she so wished, she could go over every detail of the week's work with each patient, without reference to notes. She remembered my cases and my analytic material better than I did myself. Later she entrusted me with the analysis of someone near and dear to her, but it should be made clear that I never had analysis by her, or by any of her analysands, so that I did not qualify to be one of her group of chosen Kleinians.

Now I must try to specify what I did get from Melanie Klein. This is difficult because at the time I simply worked on the material of my cases, and on cases she told me about, and I had no idea that what was being taught me was highly original. The thing was that it made sense, and joined up my case-history details with psycho-analytic theory.

For Melanie Klein child analysis was exactly like adult analysis. This was never a trouble from my point of view as I started

with the same view, and I hold this view now. The idea of a preparatory period belongs to the type of case, not to a set technique belonging to child analysis.

Then Melanie Klein used sets of very small toys. These I found truly valuable, as they are easily manipulated and they join up with the child's imagination in a special way. It was an advance on talking and also on the drawing which I always used because of the convenience of one's having the drawings to keep to remind one of the nightmare or sample of playing.

Melanie Klein had a way of making inner psychic reality very real. For her a specific play with the toys was a projection from the child's psychic reality which is localized by the child, localized inside the self and the body.

In this way I grew up thinking of the child's manipulation of the little toys, and other special and circumscribed playing as glimpses into the child's inner world, and one saw that psychic reality can be referred to as 'inner' because it does belong to the child's concept of himself (or herself) as having an inside that is part of the self and an outside that is not-me and that is repudiated.

So in this way there was a close connexion between the mental mechanisms of introjection and the function of eating. Also projection had a relation to the bodily functions that are excretory—saliva, sweat, faeces, urine, screaming, kicking, etc.

In this way the material of an analysis either had to do with the child's object relationship or with the mechanisms of introjection and projection. Also the term object relationship could mean relationship to inner or to external objects. The child thus grew in a world, both the child and the world all the time being enriched by projection and introjection. The material for projection and introjection had a pre-history, however, for at basis what is in and of the child was at first taken in in relation to the bodily function of eating. In this way, while one could analyse for ever in terms of projection and introjection, the changes came about in relation to the eating, that is the oral erotism and sadism.

Following this, angry biting in the transference in relation to a week-end or a holiday would lead to an increase in the strength of the internal objects that had a persecutory quality. In consequence of this the child had a pain, or felt threatened within, or was sick, or else by the mechanisms of projection the child felt threatened from outside, developed phobias or had threatening fantasies either awake or asleep, or became suspicious. And so on.

Thus a very rich analytic world opened up for me, and the

material of my cases confirmed the theories and did so repeatedly. In the end I came to take it all for granted. In any case these ideas are adumbrated in Freud's 'Mourning and Melancholia' (1917); and Abraham (1916) (Klein's teacher in Berlin) opened up the new territory which Melanie Klein so much enjoyed pegging out.

The important thing for me was that while none of the impact of the Oedipus complex was lost, work was now being done on the basis of anxieties related to pregenital drives. One could see that in the more or less pure psycho-neurotic case the pregenital material was regressive and the dynamics belonged to the four-year-old period, but on the other hand, in many cases, there was illness and an organization of defences belonging to the earlier times in the infant's life, and many infants never in fact arrived at so healthy a thing as an Oedipus complex at toddler age.

In my second child training case in the early thirties I was lucky in that I had a girl of three who had started her illness (anorexia) on her first birthday. The material of the analysis was Oedipal, with reactions to the primal scene, and the child was in no way psychotic. Moreover she got well and she is now married happily and rearing her own family. But her Oedipus conflict started on her first birthday when she for the first time sat at table with her two parents. The child, who had shown no symptoms previously, reached out for food, solemnly looked at her two parents, and withdrew her hand. Thus started a severe anorexia, at exactly one year. In the material of the analysis the primal scene appeared as a meal, and sometimes the parents ate the child, whereas at other times the child upset the table (bed) and destroyed the whole set-up. Her analysis was finished in time for her to have a genital Oedipus complex before the onset of the latency period.

But this was an old-fashioned case. Melanie Klein's approach enabled me to work on the infantile conflicts and anxieties and primitive defences whether the patient was child or adult, and gradually threw light on the theory of reactive depression (started by Freud) and the theory of some states characterized by persecutory expectation, and made sense of such things as the clinical alternations to and fro between hypochondria and delusions of persecution, and between depression and the obsessional defence.

All the time working with Klein I found that there was no variation on the strict application of Freudian principles of technique. There was a careful avoidance of stepping outside the analyst's role, and the main interpretations were transference interpretations. This was natural for me because my own analyst

was strictly orthodox. [Later I had a second analyst: Mrs Joan Riviere.]

What I did find was a much enriched understanding of the material presented, and in particular I found it to be valuable to be in a position to localize the item of psychic reality, inside or outside, and to get free of the use of the phrase 'weaker fantasy', even spelt with a 'ph'.

Working along Klein lines one came to an understanding of the complex stage of development that Klein called the 'depressive position'. I think this is a bad name, but it is true that clinically, in psycho-analytic treatments, arrival at this position involves the patient in being depressed. Here being depressed is an achievement, and implies a high degree of personal integration, and an acceptance of responsibility for all the destructiveness that is bound up with living, with the instinctual life, and with anger at frustration.

Klein was able to make it clear to me from the material my patients presented, how the capacity for concern and to feel guilty is an achievement, and it is this rather than depression that characterizes arrival at the depressive position in the case of the growing baby and child.

Arrival at this stage is associated with ideas of restitution and reparation, and indeed the human individual cannot accept the destructive and aggressive ideas in his or her own nature without experience of reparation, and for this reason the continued presence of the love object is necessary at this stage since only in this way is there opportunity for reparation.

This is Klein's most important contribution, in my opinion, and I think it ranks with Freud's concept of the Oedipus complex. The latter concerns a three-body relationship and Klein's depressive position concerns a two-body relationship—that between the infant and the mother. The main ingredient is a degree of ego-organization and strength in the baby or young child, and for this reason it is difficult to place the beginnings of the depressive position earlier than 8–9 months, or a year. But what does it matter?

All this belongs to the era between the wars, when there was rapid growth in the British Society and when Klein was the fertilizing agent. Paula Heimann and Susan Isaacs were in support, and also Joan Riviere, my second analyst.

Since those days a great deal has happened, and I do not claim to be able to hand out the Klein view in a way that she would herself approve of. I believe my views began to separate out from hers, and in any case I found she had not included me

in as a Kleinian. This did not matter to me because I have never been able to follow anyone else, not even Freud. But Freud was easy to criticize because he was always critical of himself. For instance, I simply cannot find value in his idea of a Death Instinct.

Well, Klein has done a great deal more that we cannot afford to ignore. She has gone deeper and deeper into the mental mechanisms of her patients and then has applied her concepts to the growing baby. I think it is here that she has made mistakes because deeper in psychology does not always mean earlier.

It has become an important part of the Klein theory to postulate a paranoid-schizoid position which dates from the very beginning. This term paranoid-schizoid is certainly a bad one, but we nevertheless cannot ignore the fact that we meet, in a vitally important way, the two mechanisms

(1) talion dread
(2) splitting of the object into 'good' and 'bad'.

Klein seemed to think at the end that infants start in this way, but this seems to ignore the fact that with good-enough mothering the two mechanisms may be relatively unimportant until the ego-organization has made the baby capable of using projection and introjection mechanisms in gaining control over objects. If there is not good-enough mothering, then the result is chaos rather than talion dread and a splitting of the object into 'good' and 'bad'.

In regard to good and bad, I think it doubtful whether these words can be used before the infant has become able to sort out benign from persecutory internal objects.

So much of what Klein wrote in the last two decades of her fruitful life may have been spoilt by her tendency to push the age at which mental mechanisms appear further and further back, so that she even found the depressive position in early weeks; also she paid lip-service to environmental provision, but would never fully acknowledge that along with the dependence of early infancy is truly a period in which it is not possible to describe an infant without describing the mother whom the infant has not yet become able to separate from a self. Klein claimed to have paid full attention to the environmental factor, but it is my opinion that she was temperamentally incapable of this. Perhaps there was a gain in this, for certainly she had a powerful drive to go further and further back into the personal individual mental mechanisms that constitute the new human being who is at the bottom rung of the ladder of emotional development.

The main point is that whatever criticism we may want to

make of Klein's standpoint in her last two decades, we cannot ignore the very great impact her work had in England, and will have everywhere, on orthodox psycho-analysis.

As for the controversy between Klein and Anna Freud, and between the followers of each, this has no importance to me, nor will it have to you, because it is a local matter, and a strong wind will blow it away. The only important thing is that psycho-analysis, firmly based on Freud, shall not miss Klein's contribution which I shall now attempt to summarize:

Strict orthodox technique in psycho-analysis of children.
Technique facilitated by use of tiny toys in initial stages.
Technique for analysis of two-and-a-half-year-old children and all ages older.
Recognition of fantasy as localized by the child (or adult), i.e. inside or outside the self.
Understanding of internal benign and persecutory forces or 'objects' and their origin in satisfactory or unsatisfactory instinctual experiences (originally oral and oral sadistic).
Importance of projection and introjection as mental mechanisms developed in relation to the child's experience of the bodily functions of incorporation and excretion.
Emphasis on the importance of destructive elements in object relationships, i.e. apart from anger at frustration.
Development of a theory of the individual's attainment of a capacity for concern (depressive position).
Relationship of constructive play
work
potency and child-bearing
to the depressive position.
Understanding of denial of depression (manic defence).
Understanding of threatened chaos in inner psychic reality and defences related to this chaos (obsessional neurosis or depressive mood).
Postulation of infantile impulses, talion fears and the splitting of the object prior to attainment of ambivalence.
Always an attempt to state the infant's psychology without reference to the quality of the environmental provision.

Then come certain more *doubtful* contributions:
Retaining a use of the theory of the Life and Death Instincts.
An attempt to state infantile destructiveness in terms of
(*a*) heredity
(*b*) envy.

17

COMMUNICATING AND NOT COMMUNICATING LEADING TO A STUDY OF CERTAIN OPPOSITES[1]

(1963)

Every point of thought is the centre of an intellectual world
(Keats)

I have started with this observation of Keats because I know that my paper contains only one idea, a rather obvious idea at that, and I have used the opportunity for re-presenting my formulations of early stages in the emotional development of the human infant. First I shall describe object-relating and I only gradually get to the subject of communicating.

Starting from no fixed place I soon came, while preparing this paper for a foreign society, to staking a claim, to my surprise, to the right not to communicate. This was a protest from the core of me to the frightening fantasy of being infinitely exploited. In another language this would be the fantasy of being eaten or swallowed up. In the language of this paper it is *the fantasy of being found.* There is a considerable literature on the psychoanalytic patient's silences, but I shall not study or summarize this literature here and now. Also I am not attempting to deal comprehensively with the subject of communication, and in fact I shall allow myself considerable latitude in following my theme wherever it takes me. Eventually I shall allow a subsidiary theme, the study of opposites. First I find I need to restate some of my views on early object-relating.

Object-Relating

Looking directly at communication and the capacity to communicate one can see that this is closely bound up with relating to objects. Relating to objects is a complex phenomenon and the development of a capacity to relate to objects is by no means a matter simply of the maturational process. As always, *maturation*

[1] Differing versions of this paper were given to the San Francisco Psychoanalytic Society, October 1962, and to the British Psycho-Analytical Society, May 1963.

(in psychology) *requires and depends on the quality of the facilitating environment.* Where neither privation nor deprivation dominates the scene and where, therefore, the facilitating environment can be taken for granted in the theory of the earliest and most formative stages of human growth, there gradually develops in the individual a change in the nature of the object. The object *being at first a subjective phenomenon becomes an object objectively perceived.* This process takes time, and months and even years must pass before privations and deprivations can be accommodated by the individual without distortion of essential processes that are basic to object-relating.

At this early stage the facilitating environment is giving the infant the *experience of omnipotence*; by this I mean more than magical control, I mean the term to include the creative aspect of experience. Adaptation to the reality principle arises naturally out of the experience of omnipotence, within the area, that is, of a relationship to subjective objects.

Margaret Ribble (1943), who enters this field, misses, I think, one important thing, which is the mother's identification with her infant (what I call the temporary state of Primary Maternal Preoccupation). She writes:

> The human infant in the first year of life should not have to meet frustration or privation, for these factors immediately cause exaggerated tension and stimulate latent defense activities. If the effects of such experiences are not skillfully counteracted, behavior disorders may result. For the baby, the pleasure principle must predominate, and what we can safely do is to bring balance into his functions and make them easy. Only after a considerable degree of maturity has been reached can we train an infant to adapt to what we as adults know as the reality principle.

She is referring to the matter of object-relating, or of id-satisfactions, but I think she could also subscribe to the more modern views on ego-relatedness.

The infant experiencing omnipotence under the aegis of the facilitating environment *creates and re-creates the object*, and the process gradually becomes built in, and gathers a memory backing.

Undoubtedly that which eventually becomes the intellect does affect the immature individual's capacity to make this very difficult transition from relating to subjective objects to relating to objects objectively perceived, and I have suggested that that which eventually gives results on intelligence testing does affect the individual's capacity to survive relative failures in the area of the adapting environment.

In health the infant creates what is in fact lying around waiting to be found. But in health *the object is created, not found.* This fascinating aspect of normal object-relating has been studied by me in various papers, including the one on 'Transitional Objects and Transitional Phenomena' (1951). A good object is no good to the infant unless created by the infant. Shall I say, created out of need? Yet the object must be found in order to be created. This has to be accepted as a paradox, and not solved by a restatement that, by its cleverness, seems to eliminate the paradox.

There is another point that has importance if one considers the location of the object. The change of the object from 'subjective' to 'objectively perceived' is jogged along less effectually by satisfactions than by dissatisfactions. The satisfaction to be derived from a feed has less value in this respect of the establishment of object-relating than when the object is, so to speak, in the way. Instinct-gratification gives the infant a personal experience and *does but little to the position of the object*; I have had a case in which satisfactions eliminated the object for an adult schizoid patient, so that he could not lie on the couch, this reproducing for him the situation of the infantile satisfactions that eliminated external reality or the externality of objects. I have put this in another way, saying that the infant feels 'fobbed off' by a satisfactory feed, and it can be found that a nursing mother's anxiety can be based on the fear that if the infant is not satisfied then the mother will be attacked and destroyed. After a feed the satisfied infant is not dangerous for a few hours, has lost object-cathexis.

Per contra, the infant's experienced aggression, that which belongs to muscle erotism, to movement, and to irresistible forces meeting immovable objects, this aggression, and the ideas bound up with it, lends itself to the process of placing the object, to placing the object separate from the self, in so far as the self has begun to emerge as an entity.

In the area of development that is prior to the achievement of fusion one must allow for the infant's behaviour that is reactive to failures of the facilitating environment, or of the environment-mother, and this may look like aggression; actually it is distress.

In health, when the infant achieves fusion, the frustrating aspect of object behaviour has value in educating the infant in respect of the existence of a not-me world. Adaptation failures have value *in so far as the infant can hate the object*, that is to say, can retain the idea of the object as potentially satisfying while recognizing its failure to behave satisfactorily. As I understand it, this

is good psycho-analytic theory. What is often neglected in statements of this detail of theory is the immense development that takes place in the infant for fusion to be achieved, and for environmental failure therefore to play its positive part, enabling the infant to begin to know of a world that is repudiated. I deliberately do not say external.

There is an intermediate stage in healthy development in which the patient's most important experience in relation to the good or potentially satisfying object is the refusal of it. The refusal of it is part of the process of creating it. (This produces a truly formidable problem for the therapist in anorexia nervosa.)

Our patients teach us these things, and it is distressing to me that I must give these views as if they were my own. All analysts have this difficulty, and in a sense it is more difficult for an analyst to be original than for anyone else, because everything that we say truly has been taught us yesterday, apart from the fact that we listen to each other's papers and discuss matters privately. In our work, especially in working on the schizoid rather than the psycho-neurotic aspects of the personality, we do in fact wait, if we feel we know, until the patients tell us, and in doing so creatively make the interpretation we might have made; if we make the interpretation out of our own cleverness and experience then the patient must refuse it or destroy it. An anorexia patient is teaching me the substance of what I am saying now as I write it down.

Theory of Communication

These matters, although I have stated them in terms of object-relating, do seem to affect the study of communication, because naturally there comes about a change in the purpose and in the means of communication *as the object changes over* from being subjective to being objectively perceived, in so far as the child gradually leaves the area of omnipotence as a living experience. In so far as the object is subjective, *so far is it unnecessary for communication with it to be explicit.* In so far as the object is objectively perceived, communication is either explicit or else dumb. Here then appear two *new* things, the individual's use and enjoyment of modes of communication, and the individual's non-communicating self, or the personal core of the self that is a true isolate.

A complication in this line of argument arises out of the fact that the infant develops two kinds of relationships at one and the same time—that to the environment-mother and that to the object, which becomes the object-mother. The environment-

mother is human, and the object-mother is a thing, although it is also the mother or part of her.

Intercommunication between infant and environment-mother is undoubtedly subtle to a degree, and a study of this would involve us in a study of the mother as much as of the infant. I will only touch on this. Perhaps for the infant there is communication with the environment-mother, brought into evidence by the experience of her *unreliability*. The infant is shattered, and this may be taken by the mother as a communication if the mother can put herself in the infant's place, and if she can recognize the shattering in the infant's clinical state. When her *reliability* dominates the scene the infant could be said to communicate simply by going on being, and by going on developing according to personal processes of maturation, but this scarcely deserves the epithet communication.

Returning to object-relating: as the object becomes objectively perceived by the child so does it become meaningful for us to contrast communication with one of its opposites.

The Objectively Perceived Object

The objectively perceived object gradually becomes a person with part objects. Two opposites of communication are:

(1) A simple not-communicating.
(2) A not-communicating that is active or reactive.

It is easy to understand the first of these. Simple not-communicating is like resting. It is a state in its own right, and it passes over into communicating, and reappears as naturally. To study the second it is necessary to think in terms both of pathology and of health. I will take pathology first.

So far I have taken for granted the facilitating environment, nicely adjusted to need arising out of being and arising out of the processes of maturation. In the psycho-pathology that I need for my argument here the facilitation has failed in some respect and in some degree, and in the matter of object-relating the infant has developed a split. By one half of the split the infant relates to the presenting object, and for this purpose there develops what I have called a false or compliant self. By the other half of the split the infant relates to a subjective object, or to mere phenomena based on body experiences, these being scarcely influenced by an objectively perceived world. (Clinically do we not see this in autistic rocking movements, for instance; and in the abstract picture that is a cul-de-sac communication, and that has no general validity?)

In this way I am introducing the idea of a communication with subjective objects and at the same time the idea of an active non-communication with that which is objectively perceived by the infant. There seems to be no doubt that for all its futility from the observer's point of view, the cul-de-sac communication (communication with subjective objects) carries all the sense of real. *Per contra*, such communication with the world as occurs from the false self does not feel real; it is not a true communication because it does not involve the core of the self, that which could be called a true self.

Now, by studying the extreme case we reach the psychopathology of severe illness, infantile schizophrenia; what must be examined, however, is the pattern of all this in so far as it can be found in the more normal individual, the individual whose development was not distorted by gross failure of the facilitating environment, and in whom the maturational processes did have a chance.

It is easy to see that in the cases of slighter illness, in which there is some pathology and some health, there must be expected an active non-communication (clinical withdrawal) because of the fact that communication so easily becomes linked with some degree of false or compliant object-relating; silent or secret communication with subjective objects, carrying a sense of real, must periodically take over to restore balance.

I am postulating that in the healthy (mature, that is, in respect of the development of object-relating) person there is a need for something that corresponds to the state of the split person in whom one part of the split communicates silently with subjective objects. There is room for the idea that significant relating and communicating is silent.

Real health need not be described only in terms of the residues in healthy persons of what might have been illness-patterns. One should be able to make a positive statement of the healthy use of non-communication in the establishment of the feeling of real. It may be necessary in so doing to speak in terms of man's cultural life, which is the adult equivalent of the transitional phenomena of infancy and early childhood, and in which area communication is made without reference to the object's state of being either subjective or objectively perceived. It is my opinion that the psycho-analyst has no other language in which to refer to cultural phenomena. He can talk about the mental mechanisms of the artist but not about the experience of communication in art and religion unless he is willing to peddle in the intermediate area whose ancestor is the infant's transitional object.

In the artist of all kinds I think one can detect an inherent dilemma, which belongs to the co-existence of two trends, the urgent need to communicate and the still more urgent need not to be found. This might account for the fact that we cannot conceive of an artist's coming to the end of the task that occupies his whole nature.

In the early phases of emotional development in the human being, silent communicating concerns the subjective aspect of objects. This links, I suppose, with Freud's concept of psychic reality and of the unconscious that can never become conscious. I would add that there is a direct development, in health, from this silent communicating to the concept of inner experiences that Melanie Klein described so clearly. In the case descriptions of Melanie Klein certain aspects of a child's play, for instance, are shown to be 'inside' experiences; that is to say, there has been a wholesale projection of a constellation from the child's inner psychic reality so that the room and the table and the toys are subjective objects, and the child and the analyst are both there in this sample of the child's inner world. What is outside the room is outside the child. This is familiar ground in psycho-analysis, although various analysts describe it in various ways. It is related to the concept of the 'honeymoon period' at the beginning of an analysis, and to the special clarity of certain first hours. It is related to dependence in the transference. It also joins up with the work that I am doing myself on the full exploitation of first hours in the short treatments of children, especially antisocial children, for whom full-scale analysis is not available and not even always advisable.

But my object in this paper is not to become clinical but to get to a very early version of that which Melanie Klein referred to as 'internal'. At the beginning the word internal cannot be used in the Klein sense since the infant has not yet properly established an ego boundary and has not yet become master of the mental mechanisms of projection and introjection. At this early stage 'inner' only means personal, and personal in so far as the individual is a person with a self in process of becoming evolved. The facilitating environment, or the mother's ego-support to the infant's immature ego, these are still essential parts of the child as a viable creature.

In thinking of the psychology of mysticism, it is usual to concentrate on the understanding of the mystic's withdrawal into a personal inner world of sophisticated introjects. Perhaps not enough attention has been paid to the mystic's retreat to a position in which he can communicate secretly with subjective

objects and phenomena, the loss of contact with the world of shared reality being counterbalanced by a gain in terms of feeling real.

A woman patient dreamed: two women friends were customs officers at the place where the woman works. They were going through all the possessions of the patient and her colleagues with absurd care. She then drove a car, by accident, through a pane of glass.

There were details in the dream that showed that not only had these two women no right to be there doing this examining, but also they were making fools of themselves by their way of looking at everything. It became clear that the patient was mocking at these two women. They would not in fact get at the secret self. They stood for the mother who does not allow the child her secret. The patient said that in childhood (nine years) she had a stolen school book in which she collected poems and sayings, and she wrote in it 'My private book'. On the front page she wrote: 'What a man thinketh in his heart, so is he.' In fact her mother had asked her: 'Where did you get this saying from?' This was bad because it meant that the mother must have read her book. It would have been all right if the mother had read the book but had said nothing.

Here is a picture of a child establishing a private self that is not communicating, and at the same time wanting to communicate and to be found. It is a sophisticated game of hide-and-seek in which *it is joy to be hidden but disaster not to be found.*

Another example that will not involve me in too deep or detailed a description comes from a diagnostic interview with a girl of seventeen. Her mother worries lest she become schizophrenic as this is a family trait, but at present it can be said that she is in the middle of all the doldrums and dilemmas that belong to adolescence.

Here is an extract from my report of the interview:

X. then went on to talk about the glorious irresponsibility of childhood. She said: 'You see a cat and you are with it; it's a subject, not an object.'

I said: 'It's as if you were living in a world of subjective objects.'

And she said: 'That's a good way of putting it. That's why I write poetry. That's the sort of thing that's the foundation of poetry.'

She added: 'Of course it's only an idle theory of mine, but that's how it seems and this explains why it's men who write poetry more than girls. With girls so much gets caught up in looking after children or having babies and then the imaginative life and the irresponsibility goes over to the children.'

We then spoke about bridges to be kept open between the imaginative life and everyday existence. She kept a diary when she was 12 and again at 14, each time apparently for a period of seven months.

She said: 'Now I only write down things that I feel in poems; in poetry something crystallizes out,'—and we compared this with autobiography which she feels belongs to a later age.

She said: 'There is an affinity between old age and childhood.'

When she needs to form a bridge with childhood imagination it has to be crystallized out in a poem. She would get bored to write an autobiography. She does not publish her poems or even show them to anybody because although she is fond of each poem for a little while she soon loses interest in it. She has always been able to write poems more easily than her friends because of a technical ability which she seems to have naturally. But she is not interested in the question: are the poems really good? or not? that is to say: would other people think them good?

I suggest that in health there is a core to the personality that corresponds to the true self of the split personality; I suggest that this core never communicates with the world of perceived objects, and that the individual person knows that it must never be communicated with or be influenced by external reality. This is my main point, the point of thought which is the centre of an intellectual world and of my paper. Although healthy persons communicate and enjoy communicating, the other fact is equally true, that *each individual is an isolate, permanently non-communicating, permanently unknown, in fact unfound.*

In life and living this hard fact is softened by the sharing that belongs to the whole range of cultural experience. At the centre of each person is an incommunicado element, and this is sacred and most worthy of preservation. Ignoring for the moment the still earlier and shattering experiences of failure of the environment-mother, I would say that the traumatic experiences that lead to the organization of primitive defences belong to the threat to the isolated core, the threat of its being found, altered, communicated with. The defence consists in a further hiding of the secret self, even in the extreme to its projection and to its endless dissemination. Rape, and being eaten by cannibals, these are mere bagatelles as compared with the violation of the self's core, the alteration of the self's central elements by communication seeping through the defences. For me this would be the sin against the self. We can understand the hatred people have of psycho-analysis which has penetrated a long way into the human personality, and which provides a threat to the human individual in his need to be secretly isolated. The question is: how to be isolated without having to be insulated?

What is the answer? Shall we stop trying to understand human beings? The answer might come from mothers who do not communicate with their infants except in so far as they are subjective objects. By the time mothers become objectively perceived their infants have become masters of various techniques for indirect communication, the most obvious of which is the use of language. There is this transitional period, however, which has specially interested me, in which transitional objects and phenomena have a place, and begin to establish for the infant the use of symbols.

I suggest that an important basis for ego development lies in this area of the individual's communicating with subjective phenomena, which alone gives the feeling of real.

In the best possible circumstances growth takes place and the child now possesses three lines of communication: communication that is *for ever silent*, communication that is *explicit*, indirect and pleasurable, and this third or *intermediate* form of communication that slides out of playing into cultural experience of every kind.

Is silent communication related to the concept of primary narcissism?

In practice then there is something we must allow for in our work, the patient's non-communicating as a positive contribution. We must ask ourselves, does our technique allow for the patient to communicate that he or she is not communicating? For this to happen we as analysts must be ready for the signal: 'I am not communicating', and be able to distinguish it from the distress signal associated with a failure of communication. There is a link here with the idea of being alone in the presence of someone, at first a natural event in child-life, and later on a matter of the acquisition of a capacity for withdrawal without loss of identification with that from which withdrawal has occurred. This appears as the capacity to concentrate on a task.

My main point has now been made, and I might stop here. Nevertheless I wish to consider what are the opposites of communication.

Opposites

There are two opposites of communication, simple non-communication, and active non-communication. Put the other way round, communication may simply arise out of not-communication, as a natural transition, or communication may be a negation of silence, or a negation of an active or reactive not-communicating.

In the clear-cut psycho-neurotic case there is no difficulty because the whole analysis is done through the intermediary of verbalization. Both the patient and the analyst want this to be so. But it is only too easy for an analysis (where there is a hidden schizoid element in the patient's personality) to become an infinitely prolonged collusion of the analyst with the patient's negation of non-communication. Such an analysis becomes tedious because of its lack of result in spite of good work done. In such an analysis a period of silence may be the most positive contribution the patient can make, and the analyst is then involved in a waiting game. One can of course interpret movements and gestures and all sorts of behavioural details, but in the kind of case I have in mind the analyst had better wait.

More dangerous, however, is the state of affairs in an analysis in which the analyst is permitted by the patient to reach to the deepest layers of the analysand's personality because of his position as subjective object, or because of the dependence of the patient in the transference psychosis; here there is danger if the analyst interprets instead of waiting for the patient to creatively discover. It is only here, at the place when the analyst has not changed over from a subjective object to one that is objectively perceived, that psycho-analysis is dangerous, and the danger is one that can be avoided if we know how to behave ourselves. If we wait we become objectively perceived in the patient's own time, but if we fail to behave in a way that is facilitating the patient's analytic process (which is the equivalent of the infant's and the child's maturational process) we suddenly become not-me for the patient, and then we know too much, and we are dangerous because we are too nearly in communication with the central still and silent spot of the patient's ego-organization.

For this reason we find it convenient even in the case of a straightforward psycho-neurotic case to avoid contacts that are outside the analysis. In the case of the schizoid or borderline patient this matter of how we manage extra-transference contacts becomes very much a part of our work with the patient.

Here one could discuss the purpose of the analyst's interpreting. I have always felt that an important function of the interpretation is the establishment of the *limits* of the analyst's understanding.

Individuals as Isolates

I am putting forward and stressing the importance of the idea of the *permanent isolation of the individual* and claiming that at the core of the individual there is no communication with the not-me

world either way. Here quietude is linked with stillness. This leads to the writings of those who have become recognized as the world's thinkers. Incidentally, I can refer to Michael Fordham's very interesting review of the concept of the Self as it has appeared in Jung's writings. Fordham writes: 'The over-all fact remains that the primordial experience occurs in solitude.' Naturally this that I am referring to appears in Wickes's *The Inner World of Man* (1938), but here it is not always certain that a distinction is always drawn between pathological withdrawal and healthy central self-communication (cf. Laing, 1961).

Among psycho-analysts there may be many references to the idea of a 'still, silent' centre to the personality and to the idea of the primordial experience occurring in solitude, but analysts are not usually concerned with just this aspect of life. Among our immediate colleagues perhaps Ronald Laing is with most deliberation setting out to state the 'making patent of the latent self' along with diffidence about disclosing oneself (cf. Laing, 1961, p. 117).

This theme of the individual as an isolate has its importance in the study of infancy and of psychosis, but it also has importance in the study of adolescence. The boy and girl at puberty can be described in many ways, and one way concerns *the adolescent as an isolate.* This preservation of personal isolation is part of the search for identity, and for the establishment of a personal technique for communicating which does not lead to violation of the central self. This may be one reason why adolescents on the whole eschew psycho-analytic treatment, though they are interested in psycho-analytic theories. They feel that by psycho-analysis they will be raped, not sexually but spiritually. In practice the analyst can avoid confirming the adolescent's fears in this respect, but the analyst of an adolescent must expect to be tested out fully and must be prepared to use communication of indirect kind, and to recognize simple non-communication.

At adolescence when the individual is undergoing pubertal changes and is not quite ready to become one of the adult community there is a strengthening of the defences against being found, that is to say being found before being there to be found. That which is truly personal and which feels real must be defended at all cost, and even if this means a temporary blindness to the value of compromise. Adolescents form aggregates rather than groups, and by looking alike they emphasize the essential loneliness of each individual. At least, this is how it seems to me.

With all this is bound up the crisis of identity. Wheelis, who has struggled with identity problems, states (1958) clearly and

crudely the problem of the analyst's vocational choice, and links this with his loneliness and need for intimacy which, in analytic work, is doomed to lead nowhere. The analyst who seems to me to be most deeply involved in these matters is Erik Erikson. He discusses this theme in the epilogue of his book, *Young Man Luther* (1958), and he reaches to the phrase 'Peace comes from the inner space' (i.e. not from outer space exploration and all that).

Before ending I wish to refer once more to the opposites that belong to negation. Melanie Klein used negation in the concept of the manic defence, in which depression that is a fact is negated. Bion (1962a) referred to denials of certain kinds in his paper on thinking, and de Monchaux (1962) continued with the theme in her comment on Bion's paper.

If I take the idea of liveliness, I have to allow for at least two opposites, one being deadness, as in manic defence, and the other being a simple absence of liveliness. It is here that silence is equated with communication and stillness with movement. By using this idea I can get behind my rooted object to the theory of the Life and Death Instincts. I see that what I cannot accept is that Life has Death as its opposite, except clinically in the manic-depressive swing, and in the concept of the manic defence in which depression is negated and negatived. In the development of the individual infant living arises and establishes itself out of not-living, and being becomes a fact that replaces not-being, as communication arises out of silence. Death only becomes meaningful in the infant's living processes when hate has arrived, that is at a late date, far removed from the phenomena which we can use to build a theory of the roots of aggression.

For me therefore it is not valuable to join the word death with the word instinct, and less still is it valuable to refer to hate and anger by use of the words death instinct.

It is difficult to get at the roots of aggression, but we are not helped by the use of opposites such as life and death that do not mean anything at the stage of immaturity that is under consideration.

The other thing that I wish to tie on to the end of my paper is an altogether different opposite to aliveness or liveliness. This opposite is not operative in the majority of our cases. Usually the mother of an infant has live internal objects, and the infant fits into the mother's preconception of a *live* child. Normally the mother is not depressed or depressive. In certain cases, however, the mother's central internal object is dead at the critical time in her child's early infancy, and her mood is one of depression. Here the infant has to fit in with a role of *dead* object, or else has

to be lively to counteract the mother's preconception with the idea of the child's deadness. Here the opposite to the liveliness of the infant is *an anti-life factor* derived from the mother's depression. The task of the infant in such a case is to be alive and to look alive and to communicate being alive; in fact this is the ultimate aim of such an individual, who is thus denied that which belongs to more fortunate infants, the enjoyment of what life and living may bring. To be alive is all. It is a constant struggle to get to the starting point and to keep there. No wonder there are those who make a special business of existing and who turn it into a religion. (I think that Ronald Laing's (1960, 1961) two books are attempting to state the predicament of this nature that many must contend with because of environmental abnormalities.) In healthy development the infant (theoretically) starts off (psychologically) without life and becomes lively simply because of being, in fact, alive.

As I have already said at an earlier stage, this being alive is the early communication of a healthy infant with the mother-figure, and it is as unselfconscious as can be. Liveliness that negates maternal depression is a communication designed to meet what is to be expected. The aliveness of the child whose mother is depressed is a communication of a reassuring nature, and it is unnatural and an intolerable handicap to the immature ego in its function of integrating and generally maturing according to inherited process.

You will have observed that I have brought the subject back to that of communication, but I do recognize that I have allowed myself a great deal of freedom in following trains of thought.

Summary

I have tried to state the need that we have to recognize this aspect of health: the non-communicating central self, for ever immune from the reality principle, and for ever silent. Here communication is not non-verbal; it is, like the music of the spheres, absolutely personal. It belongs to being alive. And in health, it is out of this that communication naturally arises.

Explicit communication is pleasurable and it involves extremely interesting techniques, including that of language. The two extremes, explicit communication that is indirect, and silent or personal communication that feels real, each of these has its place, and in the intermediate cultural area there exists for many, but not for all, a mode of communication which is a most valuable compromise.

18

TRAINING FOR CHILD PSYCHIATRY[1]

(1963)

I have found it very difficult to write this paper. The reason, I believe, is that in this discussion we are concerned neither with scientific nor with poetic truth.

Indeed, what I have to say *must* be affected by the history of my own development, it *must* be prejudiced according to my feelings about certain key matters, and it *must* be a sub-total statement in accordance with the limited scope of one man's experience.

Quite simply, I wish to state that the work we do which is at present called child psychiatry is a speciality on its own. If we retain the term 'child psychiatry', we must be quite clear that it is not a part of general psychiatry.

I shall explore the relationship of our work to the work of neighbouring specialities, and I shall make a few positive suggestions.

The training of child psychiatrists depends on our views on the nature of the work we do, and I shall put in a plea for the retention of variety in the matter of portals of entry. In particular let no overhead planning exclude the possibility of entry into child psychiatry through paediatrics.

I shall assume that at the Child Guidance Training Centre and at the Tavistock Clinic and the Maudsley Child Psychiatry Department the same questions are being asked that I am asking in this paper. Recently there was a discussion on this subject at the Tavistock Clinic, and those who were present will agree that the ground was pretty well covered on that occasion.

What is Child Psychiatry?

The question that must be asked first is: what is child psychiatry? In child psychiatry the work is essentially practical. In respect of each case we meet a challenge. In terms of bringing about clinical improvement we may fail, and we often succeed. Real failure can only be stated in terms of *a failure to meet the*

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challenge of the case. For this reason the part of our work that is done privately and apart from team-work shows us more than team-work does that the need in each case is for someone to meet someone at a deep level. It is generally accepted that the case conference is of no value unless afterwards someone carries over into a personal relationship the new understanding that discussion has brought. New understanding does nothing by itself.

The basis of much of the work of the child psychiatrist is the psycho-therapeutic interview with the child. If he has not the skill for this, or is not a suitable person to make contact with the child in this way, he cannot even make a diagnosis, let alone know how to alter a fixed situation, or understand what the other members of his team are doing. A training scheme must take this into account.

Likewise the child psychiatrist is engaged in working with the parents. Or it may be that he is in search of a plan that would enable the mother, or the father, or someone *in loco parentis*, to provide a suitable environment for a child during a phase of difficulty. The theory behind this is that suitable environmental provision facilitates the internal maturational process.

Often we find we are making a diagnosis of health, or normality, in face of the undoubted existence of symptoms in the child's developing relationship to the self, to the parents, to the family unit, and to the environment generally. Health is almost synonymous with maturity—maturity at age.

A Classification

It is not possible, I find, to make a comprehensive statement of our work, but instead I shall attempt a rough classification:

Cases Manifesting:

(*a*) Inherent difficulties in the emotional development of the individual.
Environmental factors that are unhelpful or actually harmful.
Symptomatology based on defence organizations relative to inherent difficulties interwoven with environmental failures.
Illness based on the failure of defences and the reorganization of new defences.

(*b*) Illness associated with or secondary to physical disease.

(*c*) Problems that take us to the borderline (paediatrics, neurology, adult psychiatry, obstetrics).

(*d*) Illness involving society: The antisocial tendency.
Co-operation with legal procedure.

(*e*) Problems at the borderline of the educational specialist.

A child psychiatrist must be medically qualified, and should have *practised* as a doctor, because he will need to take responsibility for life and death, and for the occasional suicide that must certainly come his way. What does he need in addition? The first answer is, of course, that he needs opportunity for experience. (Here I was lucky, because as physician in my own right at The Queen's (now Queen Elizabeth) Hospital for Children for ten years, and at Paddington Green Children's Hospital from 1923 till now, I had a medical department of my own that I could exploit as I wished. Hector Cameron had just this. But it must be rare for anyone to have such an opportunity to come to child psychiatry slowly and naturally.) The moral here is that we must plan to allow those who wish to specialize our way to have the chance to develop at a natural pace. If, on the other hand, the child psychiatrist who is starting is immediately asked to do teaching, then he must teach what others have said and not what he himself has discovered, which is a pity.

The Backing for Child Psychiatry

But my main theme needs to be stated. I will approach it this way. The educational psychologist has the backing of education, and I am glad; it supports his learning process, it gives him status, and it looks after his finances. Now, who shall back those who are clinically involved? The universities are suspicious of the practical application of psychology in terms of human affairs, especially where individual human beings are being helped; also the universities are suspicious of psychology unless it keeps on the academic rails and eschews working with the dynamic unconscious.

The social workers of various kinds are struggling to establish themselves as professional workers. What about the child psychiatrists? Who shall give them backing (except that which they automatically get by being medically qualified)?

We need only consider two types of backing, paediatrics and psychiatry, and we can say that in each case we have been so badly let down that we now cannot consider anything but autonomy. The fact that our chairman is a paediatrician can rightly be taken to indicate that there exist enlightened paediatricians now who are not only friendly but who are actively supportive. Also at Paddington Green and then (since we became absorbed) at St Mary's, I have been treated generously, and with great friendliness. But I cannot allow my own good fortune to blind me to the general position. Paediatrics has failed as a parental figure for child psychiatry, and so has psychiatry.

I will first refer to adult psychiatry and then to paediatrics, and then attempt to formulate something positive.

Psychiatry

How far can general psychiatry be trusted with the task of representing child psychiatry at planning level? I suggest that the general psychiatrist is not usually aware of what a child psychiatrist does and is. If this be so, how can he represent child psychiatry? There are of course vast areas of overlap between general psychiatry and child psychiatry. Who could say whether mental defect is psychiatric, neurological or paediatric? No need to decide. Also adolescence gradually merges into adulthood, and so child psychiatry overlaps with adult psychiatry when patients get stuck at the time when their teenage doldrums normally resolve. Also, parents and parent figures are frequently to be recognized as ill in a psychiatric sense; and adult type psychiatric syndromes do periodically appear in the child psychiatry clinic. There will always be a proportion of those entering child psychiatry who graduate first in adult psychiatry, and I have no wish to see this altered. In any case we need the adult psychiatrist to look after us when we ourselves go ungracefully into a decline. But I do wish to express the opinion that, for us, adult psychiatry is concerned with alien problems. If your son wishes to enter child psychiatry, if you advise him first to become a psychiatrist you are advising him to waste a great deal of time which he could be better spending in paediatrics.

Is it not true that adult psychiatry grew out of a concern for people who had diseased brains or who were thought to have a physical or inherited disorder? Is it not true that adult psychiatry has clung on to the biochemistry and the neurophysiology of mental disorder, at the expense, in this country, of a study of the contribution that could be made through co-operation with dynamic psychology? This is understandable in view of the fact that the adult psychiatrist has to cope with the enormous burden of the degenerated insane and with the almost insoluble problem of their nursing needs. But these same considerations make it necessary for child psychiatry to separate itself off from adult psychiatry, especially in respect of training.

Areas of Concern

Adult psychiatry is concerned with two sets of problems:

(*a*) Disorder of the mind secondary to inherited tendencies, to brain tissue deficiency, to brain tissue disease, to general

degenerative diseases, such as arteriosclerosis, which incidentally affect the brain.

(*b*) Disorders of the mind which are *late* evidence of *early* emotional distress.

In this second category may come the majority of adult psychiatric cases, and here the adult psychiatrist *always comes too late* to the field. In all these latter cases, the time at which the illness started was in the patient's infancy or early childhood. The paediatrician was the doctor who was naturally involved at the time of maximum stress, but fortunately for his peace of mind the paediatrician did not know. If he did, then he may have called for help from the child psychiatrist, and a proportion of the adult psychiatrist's cases are therapeutic failures of the combined paediatric and child psychiatric departments. Our successes manage to avoid coming to the department of adult psychiatry.

Child psychiatry is concerned with:

(*a*) The development of the personality and the character of the individual *in health*, and in various family and social patterns.

(*b*) The disorders of emotional development at their beginning, and in the early stages, when the defences are in process of hardening into syndromes, and as these interweave with the environmental provision and reaction.

The vast majority of our cases can be dealt with satisfactorily (as clinical problems) and every improvement we initiate is expanded into a larger improvement because our patients are immature and growth-process can be set free. We scarcely meet with disorders due to degeneration of tissues, and this distinguishes us from the adult psychiatrist. Moreover, we can usually rely on the parents to provide the patient's nursing home or mental hospital by their adaptation to the ill child's needs at home.

Psychiatry and the Theory of Personality Development

While I am exploring this area I want to say that I personally am not impressed when I look at the contribution made by adult psychiatry to the understanding of the developmental processes that lead to the growth of the personality and to the establishment of character. It is said that the practice of psychiatry has greatly advanced in the last thirty years, but on the debit side a few things could be said also. Here I definitely let myself go in expression of some personal opinions. With the passing of the word asylum it has become almost impossible for an ill patient

to find asylum, unless perhaps in a religious house. Also, treatment by fits has produced clinical improvement in very many cases, but has it added anything at all to the understanding of the way illness develops or treatment produces change? Perhaps by giving fits the psychiatrist helps the patient to commit suicide without dying? And in a course of convulsion therapy, the hatred of the treatment that the patient develops, that is to say, hatred without murder, may produce valuable integration in a disintegrated personality. But if these theories have truth in them they do not come from psychiatry. Lastly, in my series of personal complaints, treatment by leucotomy *really shocked me,* and gave me a suspicion of adult psychiatry from which I shall not hope to recover. In leucotomy, which has now mercifully gone out, I can only see the patient's insane delusion being met by a delusion on the part of the doctor.

Perhaps but few share these, my personal prejudices. There is a reluctance on the part of dog to eat dog and on the part of medical men and women to criticize colleagues. There are moments, however, when we must criticize and expect to be criticized, and we can do this within a framework of respect for one another as persons.

I am glad I never did work in a mental hospital where I would have had to do these bad things. I could not have done them, and I should have reverted to physical paediatrics, where I could have enjoyed myself immensely. But I would then have missed much that I value in the practice of child psychiatry.

Paediatrics

I now come to the subject of paediatrics. As is well known, my bias is towards paediatrics as the natural training ground for child psychiatry. Paediatrics gives the student and the doctor the very best opportunity for really getting to know the child patients and the parents. If paediatricians wish, they can be child psychiatrists without even knowing it. The paediatrician has to be fully equipped to deal with physical emergencies and this puts him in a very strong position in the management of doctor-parent relationships; in the guise of infant-feeding, the paediatrician can, if he is so minded, work in with the mother in her very delicate task of introducing the world to the baby, and therefore of laying down for the child the mental health which is the negative of the mental hospital disorders. It was as a practising paediatrician that I found the therapeutic value of history-taking, and discovered the fact that this provides the best

opportunity for therapeutics, provided that the history-taking is not done for the purpose of gathering facts. Psycho-analysis for me is a vast extension of history-taking, with therapeutics as a by-product.

I have continued throughout my career to believe in paediatrics as the proper root of child psychiatry, and the main thing that I wish to say in this paper is that in any planning that is to be made, the way must be left open for the doctor who wishes to come to child psychiatry through paediatrics. I mean the practice of paediatrics, over a decade. If he is to be compelled to go through the adult psychiatry training, if he is to take the D.P.M.,[1] then he must inevitably cease to be a practising paediatrician in the true sense of the term. There is so much to be learned and *experienced in the practice* of paediatrics that it is not possible to embrace another speciality such as psychiatry, which has so much in it that in no way concerns infants or children.

I hold this view very strongly in spite of the fact that paediatrics has failed to play the part that it was destined to play in relation to child psychiatry. Twenty-five years have been wasted now since those who are responsible for paediatrics in this country were introduced to the idea that child psychiatry is one half of paediatrics. Official paediatrics has avoided the issue quite deliberately, and there is now nothing to be gained by waiting longer for child psychiatry to become a twin with physical paediatrics. This could have been done, but it has not been done.

Child Psychiatry in its Own Right

But it is open to child psychiatry to give preference to paediatricians, and to ask for paediatric training and experience. The only solution is for child psychiatry to become a thing in its own right and to devise its own training. I would like to ask, has the Professor of Paediatrics ever met the Professor of Psychiatry to discuss this question of there being one day a Professor of Child Psychiatry?

But, and here is a very big but, sometimes paediatricians tend to think they can simply switch over to child psychiatry, as by changing the name from 'paediatrics' to 'child health'. This of course is not possible. If they come over to child psychiatry they must be prepared to re-orientate and to drop much of the power that they wield as physical paediatricians.

[1] Diploma of Psychological Medicine.

Place of Psycho-Analysis

This leads on to the matter of the relationship between child psychiatry and psycho-analysis and I will be brief because I believe this is not intended to become a main issue at this meeting. But I cannot avoid the issue. Committed as I am to the idea that paediatrics is the best of the various possible preparations for child psychiatry, I have to go quickly on to an assertion that the really necessary preparation for child psychiatry (whether of paediatrician or psychiatrist) is in *the psycho-analytic training*. It is an important thing for me that what I have to say about this is now generally recognized, whereas a few years ago it was quite revolutionary. It is now in my experience an *asset* when a candidate applies for a child psychiatry post if he is an analyst or if he has been accepted as a student at the Institute of Psycho-Analysis. (For the purposes of this discussion I must here include the Jungian training, in spite of the important differences which we can find between the two disciplines if we are looking for differences.) Many child psychiatrists in charge of clinics today have completed one of these trainings. This does not mean of course that the psycho-analytic training equips the candidate for child psychiatry; it concerns only the training in the psycho-analysis of adults and of children. But it does include the teaching of a theory of child development which is dynamic and which can be applied. Some institutions which go further and train in child psychiatry, e.g. the Tavistock Clinic, more or less insist on a psycho-analytic training; at others it is quite common, and Miss Freud's Hampstead Clinic, where lay psychotherapists can receive training, is of course orientated to psycho-analysis and the theories that belong to psycho-analysis.

My point is that a paediatrician who is capable of taking responsibility for his cases has a very good opportunity for developing into a child psychiatrist if, at the same time that he is gaining experience on the physical side, he is able to take the psycho-analytic training.

Selection

All this links up with the idea of selection.

The important thing in the psycho-analytic training is the personal analysis of the candidate. For the purpose of this paper I would like to take this personal analysis as being a part of selection. The psycho-analytic training is given after *selection*, and selection procedure is taken very seriously. First there is self-selection; then there is selection; and then there is further self-selection which goes with the patient's own analysis. In regard to

child psychiatry, it is essential that careful selection according to personality and according to health and maturity should be made by a responsible body. The crux of the matter is: who shall select and continue to select and have the right to reject the child psychiatry aspirant? This is an important contribution that could be made by The Institute of Psycho-Analysis. It is not at all certain, for instance, that the doctor that you would certainly call in to look after your own infant in a physical emergency, or the psychiatrist to whom you would send your mother or brother, would be the one you would select for practice in child psychiatry. This is a matter that is fraught with difficulties, but the idea that there should be an entry into child psychiatry that is free from selection is a much worse prospect than that there should be child psychiatrists who have not got the D.P.M., or have not worked in a mental hospital.

Conclusion

First let us establish child psychiatry as a thing in its own right; then let adult psychiatrists continue to enter the child psychiatry field, if they are willing to study the physical and emotional development of the infant and child and to undergo a psychoanalytic training which includes a selection procedure and a personal analysis. Also, allow the paediatrician the same chance with the same proviso. But these things cannot be done without the active co-operation of official psychiatry and official paediatrics, since financial help must be found for the analytic training. Also there should be a willing facilitation of the paediatrician's, or the psychiatrist's, or the child's psychiatrist's, valiant effort to fit an analytic training in with the whole-time job that provides the basic security which is necessary for the founding of a home and family.

Summary

Child psychiatry is a speciality on its own account, whereas general psychiatry is concerned with degenerative processes and with neurological phenomena that are not important in the average child psychiatry department. Child psychiatry is concerned with the emotional development of the individual child and with the interferences with maturational processes that come from the environment and from conflict within the child. This makes child psychiatry akin to paediatrics.

The general psychiatrist or the paediatrician needs additional

training of the kind provided by Psycho-Analysis and Analytical Psychology. These Institutes also provide machinery for selection.

There will always be those who come to child psychiatry from general psychiatry, but it is important to keep open the route through paediatric practice.

19

PSYCHOTHERAPY OF CHARACTER DISORDERS[1]

(1963)

Although the title chosen for this paper is the 'Psychotherapy of Character Disorders', it is not possible to avoid a discussion of the meaning of the term 'Character Disorder'. As Fenichel (1945, p. 539) remarks,

> The question may be raised whether there is any analysis that is not 'character analysis'. All symptoms are the outcome of specific ego attitudes, which in analysis make their appearance as resistances and which have been developed during infantile conflicts. This is true. And to a certain degree, really, all analyses are character analyses.

And again,

> Character disorders do not form a nosological unit. The mechanisms at the basis of character disorder may be as different as the mechanisms at the basis of symptom neuroses. Thus a hysterical character will be more easily treated than a compulsive one, a compulsive one more easily than a narcissistic one.

It is clear that either the term is too wide to be useful, or else I shall need to use it in a special way. In the latter case I must indicate the use I shall make of the term in this paper.

First, there must be confusion unless it be recognized that the three terms: character, a good character, and a character disorder, bring to mind three very different phenomena, and it would be artificial to deal with all three at one and the same time, yet these three are inter-related.

Freud wrote (1905b) that 'a fairly reliable character' is one of the prerequisites for a successful analysis (Fenichel, 1945, p. 537); but we are considering *unreliability* in the personality, and Fenichel asks: can this unreliability be treated? He might have asked: what is its aetiology?

When I look at character disorders I find I am looking at *whole persons*. There is in the term an implication of a degree of integration, itself a sign of psychiatric health.

[1] Read at the 11th European Congress of Child Psychiatry, Rome, May–June 1963.

The papers that have preceded mine have taught us much, and have strengthened me in the idea of character as something that belongs to integration. Character is a manifestation of successful integration, and a disorder of character is a distortion of the ego structure, integration being nevertheless maintained. It is perhaps good to remember that integration has a time factor. The child's character has formed on the basis of a steady developmental process, and in this respect the child has a past and a future.

It would seem to be valuable to use the term character disorder in description of a child's attempt to accommodate his or her own developmental abnormalities or deficiencies. Always we assume that the personality structure is able to withstand the strain of the abnormality. The child needs to come to terms with the personal pattern of anxiety or compulsion or mood or suspicion, etc., and also to relate this to the requirements and expectations of the immediate environment.

In my opinion the value of the term belongs specifically to a description of personality distortion that comes about *when the child needs to accommodate some degree of antisocial tendency.* This leads immediately to a statement of my use of this term.

I am using these words which enable us to focus our attention not so much on behaviour as on those roots of misbehaviour that extend over the whole area between normality and delinquency. The antisocial tendency can be examined in your own healthy child who at the age of two takes a coin from his mother's handbag.

The antisocial tendency always arises out of a *deprivation* and represents the child's claim to get back behind the deprivation to the state of affairs that obtained when all was well. I cannot develop this theme here, but this thing that I call the antisocial tendency must be mentioned because it is found regularly in the dissection of character disorder. The child in accommodating the antisocial tendency that is his or hers may hide it, may develop a reaction formation to it, such as becoming a prig, may develop a grievance and acquire a complaining character, may specialize in day-dreaming, lying, mild chronic masturbating activity, bed-wetting, compulsive thumb-sucking, thigh-rubbing, etc., or may periodically manifest the antisocial tendency (that is his or hers) in a *behaviour disorder.* This latter is always associated with hope, and it is either of the nature of stealing or of aggressive activity and destruction. It is compulsive.

Character disorder, then, according to my way of looking at things, refers most significantly to the distortion of the *intact* per-

sonality that results from the antisocial elements in it. It is the antisocial element that determines society's involvement. Society (the child's family and so on) must meet the challenge, and must *like or dislike* the character and the character disorder.

Here then is the beginning of a description:

Character disorders are not schizophrenia. In character disorder there is hidden illness in the intact personality. Character disorders in some way and to some degree actively involve society.

Character disorders may be divided according to:

Success or failure on the part of the individual in the attempt of the total personality to hide the illness element. Success here means that the personality, though impoverished, has become able to socialize the character distortion to find secondary gains or to fit in with a social custom.

Failure here means that the impoverishment of the personality carries along with it a failure in establishment of a relation to society as a whole, on account of the hidden illness element.

In fact, society plays its part in the determination of the fate of a person with character disorder, and does this in various ways. For example:

Society tolerates individual illness to a degree.

Society tolerates failure of the individual to contribute-in.

Society tolerates or even enjoys distortions of the mode of the individual's contributing-in.

or Society meets the challenge of the antisocial tendency of an individual, and its reaction is being motivated by:

(1) Revenge.
(2) The wish to socialize the individual.
(3) Understanding and the application of understanding to prevention.

The individual with character disorder may suffer from:

(1) Impoverishment of personality, sense of grievance, unreality, awareness of lack of serious purpose, etc.
(2) Failure to socialize.

Here then is a basis for psychotherapy, because psychotherapy relates to individual *suffering* and need for help. But this suffering in character disorder only belongs to the early stages in the individual's illness; the secondary gains quickly take over, lessen

the suffering, and interfere with the drive of the individual to seek help or to accept help offered.

It must be recognized that in respect of 'success' (character disorder hidden and socialized) *psychotherapy makes the individual ill*, because illness lies between the defence and the individual's health. By contrast, in respect of 'unsuccessful' hiding of character disorder, although there may be an initial drive in the individual to seek help at an early stage, because of society's reactions, this motive does not necessarily carry the patient through to the treatment of the deeper illness.

The clue to the treatment of character disorder is given by the part the environment plays in the case of *natural cure*. In the slight case the environment can 'cure' because the cause was an environmental failure in the area of ego-support and protection at a stage of the individual's dependence. This explains why it is that children are regularly 'cured' of incipient character disorder in the course of their own childhood development simply by making use of home life. Parents have a second and third chance to bring their children through, in spite of failures of management (mostly inevitable) in the earliest stages when the child is highly dependent. Family life is the place therefore that offers the best opportunity for investigation into the aetiology of character disorder; and indeed it is in the family life, or its substitute, that the child's *character* is being built up in positive ways.

Aetiology of Character Disorder

In considering the aetiology of character disorder it is necessary to take for granted both the maturational process in the child, the conflict-free sphere of the ego (Hartmann), also forward movement with anxiety drive (Klein), and the function of the environment which facilitates the maturational processes. Environmental provision must be 'good' enough if maturation is to become a fact in the case of any one child.

With this in mind, one can say that there are two extremes of distortion, and that these relate to the stage of maturation of the individual at which environmental failure did actually overstrain the ego's capacity for organizing defences:

At one extreme is the ego hiding *psycho-neurotic* symptom-formations (set up relative to anxiety belonging to the Oedipus complex). Here the hidden illness is a matter of conflict in the individual's personal unconscious.

At the other extreme is the ego hiding *psychotic* symptom-formations (splitting, dissociations, reality side-slipping, de-

personalization, regression and omnipotent dependencies, etc.). Here the hidden illness is in the ego structure.

But the matter of society's essential involvement does not depend on the answer to the question: is the hidden illness psycho-neurotic or psychotic? In fact, in character disorder there is this other element, *the individual's* correct perception at a time in early childhood that at first all was well, or well enough, and then that all was not well. In other words, that there happened at a certain time, or over a phase of development, an actual failure of ego-support that held up the individual's emotional development. A reaction in the individual to this disturbance took the place of simple growth. The maturational processes became dammed up because of a failure of the facilitating environment.

This theory of the aetiology of character disorder, if correct, leads to a new statement of character disorder at its inception. The individual in this category carries on with two separate burdens. One of these, of course, is the increasing burden of a disturbed and in some respects stunted or postponed maturational process. The other is the hope, a hope that never becomes quite extinguished, that the environment may acknowledge and make up for the specific failure that did the damage. In the vast majority of cases the parents or the family or guardians of the child recognize the fact of the 'let-down' (so often unavoidable) and by a period of special management, spoiling, or what could be called mental nursing, they see the child through to a recovery from the trauma.

When the family does not mend its failures the child goes forward with certain handicaps, being engaged in

(1) arranging to live a life in spite of emotional stunting, and
(2) all the time liable to moments of hope, moments when it would seem to be possible to force the environment to effect a cure (hence: acting-out).

Between the clinical state of a child who has been hurt in the way that is being described here and the resumption of that child's emotional development, and all that that means in terms of socialization, there is this need to make society acknowledge and repay. Behind a child's maladjustment is always a failure of the environment to adjust to the child's absolute needs at a time of relative dependence. (Such failure is initially a failure of nurture.) Then there can be added a failure of the family to heal the effects of such failures; and then there may be added the failure

of society as it takes the family's place. Let it be emphasized that in this type of case the initial failure can be shown to have happened at a time at which the child's development had made it just possible for him or her to perceive the fact of the failure and to perceive the nature of the environment's maladjustment.

The child now displays an antisocial tendency, which (as I have said) in the stage before the development of secondary gains is always a manifestation of hope. This antisocial tendency is liable to show in two forms:

(1) The staking of claims on people's time, concern, money, etc. (manifested by stealing).
(2) The expectation of that degree of structural strength and organization and 'comeback' that is essential if the child is to be able to rest, relax, disintegrate, feel secure (manifested by destruction which provokes strong management).

On the basis of this theory of the aetiology of character disorder I can proceed to examine the matter of therapy.

Indications for Therapy

Therapy of character disorder has three aims:

(A) A dissection down to the illness that is hidden and that appears in the character distortion. Preparatory to this may be a period in which the individual is invited to become a patient, to become ill instead of hiding illness.
(B) To meet the antisocial tendency which, from the point of view of the therapist, is evidence of hope in the patient; to meet it as an S.O.S., a *cri de cœur*, a signal of distress.
(C) Analysis that takes into consideration both the ego distortion and the patient's exploitation of his or her id-drives during attempts at self-cure.

The attempt to meet the patient's antisocial tendency has two aspects:

> The allowance of the patient's claims to rights in terms of a person's love and reliability.
> The provision of an ego-supportive structure that is relatively indestructible.

As this implies, the patient will from time to time be acting-out, and as long as this has a relation to the transference it can be managed and interpreted. The troubles in therapy come in relation to antisocial acting-out which is outside the total thera-

peutic machinery, that is to say, which involves society.

In regard to the treatment of hidden illness and of ego distortion, the need is for psychotherapy. But at the same time the antisocial tendency must be engaged, as and when it appears. The aim in this part of the treatment is to arrive at the original trauma. This has to be done in the course of the psychotherapy, or if psychotherapy is not available, in the course of the specialized management that is provided.

In this work the failures of the therapist or of those managing the child's life will be real and they can be shown to reproduce the original failures, in token form. These failures are real indeed, and especially so in so far as the patient is either regressed to the dependence of the appropriate age, or else remembering. The acknowledgement of the analyst's or guardian's failure enables the patient to become appropriately angry instead of traumatized. *The patient needs to reach back through the transference trauma to the state of affairs that obtained before the original trauma.* (In some cases there is a possibility of quick arrival at deprivation trauma in a first interview.) The reaction to the current failure only makes sense in so far as the current failure *is* the original environmental failure from the point of view of the child. Reproduction in the treatment of examples as they arise of the original environmental failure, along with the patient's experience of anger that is appropriate, frees the patient's maturational processes; and it must be remembered that the patient is in a dependent state and needing ego-support and environmental management (holding) in the treatment setting, and the next phase needs to be a period of emotional growth in which the character builds up positively and loses its distortions.

In a favourable case the acting-out that belongs to these cases is confined to the transference, or can be brought into the transference productively by interpretation of displacement, symbolism, and projection. At one extreme is the common 'natural' cure that takes place in the child's family. At the other extreme are the severely disturbed patients whose acting-out may make treatment by interpretation impossible because the work gets interrupted by society's reactions to stealing or destructiveness.

In a moderately severe case the acting-out can be managed provided that the therapist understands its meaning and significance. It can be said that acting-out is the alternative to despair. Most of the time the patient is hopeless about correcting the original trauma and so lives in a state of relative depression or of dissociations that mask the chaotic state that is always threatening. When, however, the patient starts to make an object

relationship, or to cathect a person, then there starts up an anti-social tendency, a compulsion either to lay claims (steal) or by destructive behaviour to activate harsh or even vindictive management.

In every case, if psychotherapy is to be successful, the patient must be seen through one or many of these awkward phases of manifest antisocial behaviour, and only too often it is just at these awkward points in the case that treatment is interrupted. The case is dropped not necessarily because the situation cannot be tolerated, but (as likely as not) because those in charge do not know that these acting-out phases are inherent, and that they can have a positive value.

In severe cases these phases in management or treatment present difficulties that are so great that the law (society) takes over, and at the same time psychotherapy goes into abeyance. Society's revenge takes the place of pity or sympathy, and the individual ceases to suffer and be a patient, and instead becomes a criminal with a delusion of persecution.

It is my intention to draw attention to *the positive element in character disorder.* Failure to achieve character disorder in the individual who is trying to accommodate some degree of antisocial tendency indicates a liability to psychotic breakdown. Character disorder indicates that the individual's ego structure can bind the energies that belong to the stunting of maturational processes and also the abnormalities in the interaction of the individual child and the family. Until secondary gains have become a feature the personality with character disorder is always liable to break down into paranoia, manic depression, psychosis or schizophrenia.

To sum up, a statement on the treatment of character disorder can start with the dictum that such a treatment is like that of any other psychological disorder, namely, psycho-analysis if it be available. There must follow the following considerations:

(1) Psycho-analysis may succeed, but the analyst must expect to find *acting-out* in the transference, and must understand the significance of this acting-out, and be able to give it positive value.
(2) The analysis may succeed but be difficult because the hidden illness has psychotic features, so that the patient must become ill (psychotic, schizoid) before starting to get better; and all the resources of the analyst will be needed to deal with the primitive defence mechanisms that will be a feature.
(3) The analysis may be succeeding, but as acting-out is not con-

fined to the transference relationship the patient is removed from the analyst's reach because of society's reaction to the patient's antisocial tendency or because of the operation of the law. There is room for great variation here, owing to the variability of society's reaction, ranging from crude revenge to an expression of society's willingness to give the patient a chance to make late socialization.

(4) In many cases incipient character disorder is treated and treated successfully in the child's home, by a phase or by phases of special management (spoiling) or by especially *personal* care or strict control by a person who loves the child. An extension of this is the treatment of incipient or early character disorder without psychotherapy by management in groups designed to give what the child's own family cannot give in the way of special management.

(5) By the time the patient comes to treatment there may already be a fixed antisocial tendency manifest, and a hardened attitude in the patient fostered by secondary gains, in which case the question of psycho-analysis does not arise. Then the aim is to provide firm management by understanding persons, and to provide this as a *treatment* in advance of its being provided as a *corrective* by court order. Personal psychotherapy can be added if it is available.

Finally,

(6) The character disorder case may present as a court case, with society's reaction represented by the probation order, or by committal to an approved school or a penal institution.

It can happen that early committal by a court proves to be a *positive* element in the patient's socialization. This corresponds again to the natural cure that commonly takes place in the patient's family; society's reaction has been, for the patient, a practical demonstration of its 'love', that is of its willingness to 'hold' the patient's unintegrated self, and to meet aggression with firmness (to limit the effects of maniacal episodes) and to meet hatred with hatred, appropriate and under control. This last is the best that some deprived children will ever get by way of satisfactory management, and many restless antisocial deprived children change from ineducable to educable in the strict regime of a remand home. The danger here is that because restless antisocial children thrive in an atmosphere of dictatorship this may breed dictators, and may even make educationalists think that an atmosphere of strict discipline, with every minute of the child's

day filled, is good educational treatment for normal children, which it is not.

Girls

Broadly speaking, all this applies equally to boys and girls. At the stage of adolescence, however, the nature of the character disorder is necessarily different in the two sexes. For example, at adolescence girls tend to show their antisocial tendency by prostitution, and one of the hazards of acting-out is the production of illegitimate babies. In prostitution there are secondary gains. One is that girls find they contribute-in to society by being prostitutes, whereas they cannot contribute-in by any other means. They find many lonely men, who want a relationship rather than sex, and who are ready to pay for it. Also, these girls, essentially lonely, achieve contacts with others of their kind. The treatment of adolescent antisocial girls who have started to experience the secondary gains of the prostitute, presents *insuperable difficulties*. Perhaps the idea of treatment does not make sense in this context. In many cases it is already too late. It is best to give up all attempts to cure prostitution, and instead to concentrate on giving these girls food and shelter and opportunity for keeping healthy and clean.

Clinical Illustrations

A Common Type of Case

A boy in later latency (first seen at ten years) was having psycho-analytic treatment from me. His restlessness and liability to outbreaks of rage started from a very early date, soon after his birth and long before he was weaned at eight months. His mother was a neurotic person and all her life more or less depressed. He was a thief and given to aggressive outbursts. His analysis was going well, and in the course of a year of daily sessions much straightforward analytic work was accomplished. He became very excited, however, as his relationship to me developed significance, and he climbed out on to the clinic roof and flooded out the clinic and made so much noise that the treatment had to stop. Sometimes there was danger to me; he also broke into my car outside the clinic and drove off in bottom gear by using the self-starter, thus obviating the need for a car key. At the same time he started stealing again and being aggressive outside the treatment setting, and he was sent by the Juvenile Court to an approved school just at a time when the treatment by psychoanalysis was in full spate. Perhaps if I had been much stronger

than he I might have managed this phase, and so have had opportunity to complete the analysis. As it was I had to give up.

(This boy did moderately well. He became a lorry driver, which suited his restlessness. He had kept his job fourteen years at the time of the follow-up. He married and had three children. His wife divorced him, after which he kept in touch with his mother, from whom the details of the follow-up were obtained.)

Three Favourable Cases

A boy of eight started stealing. He had suffered a relative deprivation (in his own good home setting) when he was two, at the time his mother conceived, and became pathologically anxious. The parents had managed to meet this boy's special needs and had almost succeeded in effecting a natural cure of his condition. I helped them in this long task by giving them some understanding of what they were doing. In one therapeutic consultation when the boy was eight it was possible for me to get this boy into feeling-contact with his deprivation, and he reached back to an object relationship to the good mother of his infancy. Along with this the stealing ceased.

A girl of eight years came to me because of stealing. She had suffered a relative deprivation in her own good home at the age of 4–5 years. In one psychotherapeutic consultation she reached back to her early infantile contact with a good mother, and at the same time her stealing disappeared. She was also wetting and messing and this minor manifestation of the antisocial tendency persisted for some time.

A boy of thirteen years, at a public school a long way from his good home, was stealing in a big way, also slashing sheets and upsetting the school by getting boys into trouble and by leaving obscene notes in lavatories, etc. In a therapeutic consultation he was able to let me know that he had been through a period of intolerable strain at the age of six when he went away to boarding school. I was able to arrange for this boy (middle child of three) to be allowed a period of 'mental nursing' in his own home. He used this for a regressive phase, and then went to day school. Later he went to a boarding school in the neighbourhood of his home. His antisocial symptoms ceased abruptly after his one interview with me and follow-up shows that he has done well. He has now passed through a university, and is establishing himself as a man. Of this case it is particularly true to say that the patient brought with him the understanding of his case, and what

he needed was for the facts to be acknowledged and for an attempt to be made to mend, in token form, the environmental failure.

Comment

In these three cases in which help could be given when secondary gains had not become a feature the general attitude of myself as psychiatrist enabled the child in each case to state a specific area of relative deprivation, and the fact that this was accepted as real and true enabled the child to reach back over the gap and make anew a relationship with good objects that had been blocked.

A Case on the Borderline between Character Disorder and Psychosis

A boy has been under my care over a period of years. I have only seen him once, and most of my contacts have been with the mother at times of crisis. Many have tried to give direct help to the boy, who is now twenty, but he quickly becomes uncooperative.

This boy has a high I.Q. and all those whom he has allowed to teach him have said that he could be exceptionally brilliant as an actor, a poet, an artist, a musician, etc. He has not stayed long at any one school but by self-tuition has kept well ahead of his peers, and he did this in early adolescence by coaching his friends in their school-work, then keeping in touch.

In the latency period he was hospitalized and diagnosed schizophrenic. In hospital he undertook the 'treatment' of the other boys, and he never accepted his position as a patient. Eventually he ran away and had a long period without schooling. He would lie in bed listening to lugubrious music, or lock himself into the house so that no one could get to him. He constantly threatened suicide, chiefly in relation to violent love affairs. Periodically he would organize a party, and this would go on indefinitely, and damage was sometimes done to property.

This boy lived with his mother in a small flat and he kept her constantly in a state of worry, and there was never any possibility of an outcome since he would not go away, he would not go to school or to hospital, and he was clever enough to do exactly as he wanted to do, and he never became criminal, and so kept out of the jurisdiction of the law.

At various times I helped the mother by putting her in touch with the police, the probation service, and other social services, and when eventually he said he would go to a certain grammar school I 'pulled strings' to enable him to do this. He was found

to be well ahead of his age group, and the masters gave him great encouragement because of his brilliance. But he left school before time, and obtained a scholarship for a good college of acting. At this point he decided that he had the wrong-shaped nose, and eventually he persuaded his mother to pay a plastic surgeon to alter it from retroussé to straight. Then he found other reasons why he could not go forward to any success, and yet he gave no one any opportunity to help him. This continues, and at present he is in the observation ward of a mental hospital, but he will find a way of leaving this and will settle in at home once more.

This boy has an early history that gives the clue to the anti-social part of his character disorder. In fact he was the result of a partnership that foundered soon after its unhappy start, and the father soon after separating from the mother himself became a paranoid casualty. This marriage followed immediately after a tragedy, and was doomed to failure because the boy's mother had not yet recovered from the loss of her much-loved fiancé whom, as she felt, was killed by the carelessness of this man whom she married and who became the father of the boy.

This boy could have been helped at an early age, perhaps six, when he was first seen by a psychiatrist. He could then have led the psychiatrist to the material of his relative deprivation, and he could then have been told about his mother's personal problem, and the reason for the ambivalence in her relationship to him. But instead the boy was placed in a hospital ward, and from this time on he hardened into a case of character disorder, becoming a person who compulsively tantalizes his mother and his teachers and his friends.

I have not attempted to describe a case treated by psycho-analysis in this series of short case-descriptions.

Cases treated by management alone are innumerable and include all those children who when deprived in one way or another are adopted, or fostered out, or placed in small homes that are run as therapeutic institutions and on personal lines. It would be giving a false impression to describe one case in this category. It is indeed necessary to draw attention to the fact that incipient character disorder is being treated successfully all the time, especially in the home, in social groups of all kinds, and quite apart from psychotherapy.

Nevertheless, it is intensive work with the few cases that throws light on the problem of character disorder as of other types of psychological disorders, and it is work of the psycho-analytic

groups in various countries that has laid the basis for a theoretical statement and has begun to explain to the specialized therapeutic groups what it is that is being done in such groups that so often succeeds in the prevention or treatment of character disorder.

20

THE MENTALLY ILL IN YOUR CASELOAD[1]

(1963)

Since the beginning of the century there has been a crescendo of attempts to rescue psychiatry from stagnation. Psychiatrists have had a big task in changing the care and treatment of mentally ill persons from mechanical restraints to a human and humane method. Then came the application of dynamic psychology to psychiatry. It is the *psychology* of mental illness that is of interest to psycho-analysts and to those who work on the basis of dynamic psychology, and this category includes many social workers. My task will be to make this link between mental illness and the stages of individual emotional development and I shall go ahead without being in a position to offer positive proof of the details of my thesis.

First, I must remind you of the psychiatrist's classification of mental disorder. I shall deal summarily with the mental disorders that arise from physical abnormality of the brain, which is the electronic apparatus upon which the mind depends for functioning. The apparatus can be faulty in various ways, hereditarily, congenitally, through infectious disease, because of a tumour, or through degenerative processes such as arteriosclerosis. Also certain general physical disorders affect the electronic apparatus, such as myxoedema, and hormone unbalance associated with the menopause. We must brush aside these considerations, important though they are, in order to get towards the area of mental disorder that is a matter of psychology, of dynamic psychology, of emotional immaturity.

I shall also have to take for granted your knowledge of the effect on mental states of bodily illness, and the threat of bodily illness. It certainly does affect a person's mentality to have cancer or heart disease. Only the psychology of these effects can concern us here now.

A classification starts, then, with these three categories:

(*a*) Diseases of the brain with consequent mental disorder.
(*b*) Diseases of the body affecting mental attitudes.
(*c*) Mental disorders proper, that is, disorders that are not dependent on brain or other physical disease.

[1] Talk given to the Association of Social Workers, London, and published in *New Thinking for Changing Needs*, by the Association of Social Workers, 1963.

From this we start to divide mental disorder into psycho-neurosis and psychosis. You will not jump to the conclusion that psycho-neurotic persons are necessarily less ill than psychotic persons. The word 'ill' needs to be examined at this point. Let me use my friend the late John Rickman's definition: 'Mental illness consists in not being able to find anyone who can stand you.' In other words, there is a contribution from society into the meaning of the word 'ill', and certainly some psycho-neurotic persons are maximally difficult to live with. Yet they are not usually certifiable. This presents a difficulty to which I will refer later.

Health is emotional maturity, emotional maturity of the individual person. Psycho-neurosis relates to the state of the person as a child of toddler age; to the positive or negative family provision; to the way in which the latency period relieved or accentuated the tensions that were operative in the individual; and to the reassembly in the various stages of adolescence of the changes in the instinctual drives, and the new organization of defences against anxiety that came to blue-print in the early childhood of the individual.

Psycho-neurosis is the term used to describe the illness of persons who became ill at the stage of the Oedipus complex, at the stage of the experience of relationships as between three *whole* people. The conflicts arising out of these relationships lead to defensive measures which, if they become organized in a relatively rigid state, qualify for the title psycho-neurosis. These defences have been listed and clearly stated. Obviously the way in which they build up and become fixed depends to some extent, perhaps to a great extent, on the history of the individual prior to his or her arrival at the stage of triangular relationships as between whole persons.

Now psycho-neurosis involves repression, and the repressed unconscious, which is a special aspect of the unconscious. Whereas the unconscious generally is the storehouse of the richest areas of a person's self, the repressed unconscious is the bin in which is held (at great cost in terms of the mental economy) that which is intolerable and beyond the capacity of the individual to accommodate as part of the self and of personal experience. The unconscious proper can be reached in dreams and contributes fundamentally to all the most significant experiences of the human individual; by contrast, the repressed unconscious is not freely available for use, and appears only as a threat or as a source of reaction formation (for example, sentimentality indicating repressed hatred). All this is the stuff of dynamic psychology.

Repression belongs to psycho-neurosis just as splitting of the personality belongs to psychosis.

Psycho-neurotic illness can be severe indeed. Moreover, this type of illness makes the social worker despair, because the repressed unconscious is the province of the psycho-analyst. By contrast, as I shall try to show, the areas of illness named psychosis, or madness, offer more scope for the social worker, and this partly because such disorders offer less scope for the psycho-analyst, unless, indeed, he steps outside his role at appropriate moments and himself becomes a social worker. (This theme will develop gradually as I proceed.)

As I have said, in psycho-neurosis one of the defences has to do with regression. The person who is ill is found to have retreated from genital sexuality and from the triangular relationships as between whole people and to have taken up certain positions that belong to his or her life prior to the stage of the hetero-sexual and homosexual positions in interpersonal matters. To some extent the fixation points, the points used in these regressive defences, depend on good and bad experiences in the individual's earlier developmental stages, and of course on the corresponding good and bad environmental factors relative to these stages.

Psychosis may be looked at as illness that has more to do with the experiences in the earlier phases than with the tensions at the level of interpersonal relationships which lead to repressive defences. In the extreme case there has been no true Oedipus complex because the individual was so much caught up in an earlier stage of development that true and full-blooded triangular relationships never became a fact.

Of course you will find cases to describe in which there can be demonstrated a mixture of normality in terms of the Oedipus complex and of psychosis in terms of being stuck at a phase of early emotional development. However, these mixed cases need not concern us here, where we are trying to state an extremely complex matter in simple terms.

Psycho-neurosis, then, belongs to the defences organized around the anxieties and conflicts of relatively normal persons, that is persons who at any rate have reached the stage of the Oedipus complex. In a treatment by psycho-analysis the analyst makes it possible for the quantity of repression to lessen, and at the end of the treatment the interpersonal relationships come to fuller expression and experience, and there is a lessening of the pregenital component of sexuality.

All the rest of mental illness (other than psycho-neurosis)

belongs to the build-up of the personality in earliest childhood and in infancy, along with the environmental provision that fails or succeeds in its function of facilitating the maturational processes of the individual. In other words, mental illness that is not psycho-neurosis has importance for the social worker because it concerns not so much the individual's organized defences as the individual's failure to attain the ego-strength or the personality integration that enables defences to form.

I can now return to classification of psychiatric types more happily because I think I may have conveyed to you the idea that madness is your province just as psycho-neurosis is the province of the orthodox Freudian analyst. Moreover madness has a relation to ordinary life. In madness we find instead of repression the processes of personality establishment and self-differentiation in reverse. This is the stuff of madness and it is this which I am principally trying to describe. Failures in the maturational process (itself a matter of heredity) are of course often associated with pathological hereditary factors, but the point is that these failures are very much associated with failures of the facilitating environment. You will see that it is here that the social worker comes in, since the environmental factor has a specific significance in the *aetiology* of madness. The basic assumption here is that the mental health of the individual is held down in the area of infant-care and child-care and both infant- and child-care reappear in the social worker's casework. In the psychotherapy of psycho-neurosis, which is essentially a disorder of inner conflict (that is to say, conflict within the intact integrated personalized and object-related self), these phenomena that derive from infant- and child-care turn up in that which is called the transference neurosis.

Let us go back then to my attempt to assemble the illnesses other than psycho-neurosis in the psychiatric classification. It would be simpler from the point of view of my presentation if I could take the two extremes and refer to psycho-neurosis at one extreme and to schizophrenia at the other. I cannot do this, however, because of the affective disorders. Between psycho-neurosis and schizophrenia lies the whole territory covered by the word depression. When I say between I really do mean that in the aetiology of these disorders the points of origin of depression lie between the points of origin of psycho-neurosis and of schizophrenia. I also mean that there is every degree of overlap, that there are no clear-cut distinctions and that in psychiatric illness it is false to label disorders as if they were diseases in the way that is characteristic of classification in physical medicine. (Here of

course I am excluding brain diseases which are really physical diseases with secondary psychological effects.)

The depressions constitute a very wide concept of mental disorder. Developments in psycho-analysis have elucidated much of the psychology of depressive illness and also have related depression to that which is essentially healthy, namely the capacity to mourn and the capacity to feel concerned. The depressions therefore range from near-normal to near-psychotic. At the normal end of the depressions come those depressive illnesses which imply maturityi n the individual and imply a degree of integration of the self. Here, as in psycho-neurosis, the psycho-analyst rather than the social worker is needed, but there is one thing which can be of great importance to the social worker, namely the tendency for depression to lift. Without doing any psychotherapy the social worker can do a great deal on the basis of allowing a depression to take its course. What is needed here is an assessment of the individual as one whose past history gives evidence that the personality integration can stand the strain of the depressive illness in which a certain type of conflict is working through. This conflict in depression roughly-speaking has to do with the individual's personal task of accommodating his or her own aggression and destructive impulsces. When someone who is loved dies, the mourning process belongs to the working-through within the individual of the feeling of personal responsibility for the death because of the destructive ideas and impulses that accompany loving. Depression at this end of the scale is formed on this pattern that is more obvious in mourning, the difference being that in depression there is a higher degree of repression and the processes take place at a level which is more unconscious (in the sense of being repressed) than in mourning.

From the psycho-analyst's point of view the psychotherapy of depression of this kind is not unlike that of psycho-neurosis except that in the transference the most powerful dynamic is in the two-body relationship based on that which was originally infant and mother. The important part of the analyst's therapeutic in the treatment of depression is his survival over a period in which destructive ideas dominate the scene, and here again the social worker who sees a depressed person through a depression is doing therapy simply by continuing to exist in person and by survival.

Allied to depressive illness of this reactive kind is that which is associated with menopausal and other types of contraction of opportunity for construction and creative contribution.

At the other extreme of this grouping of the depressions is

psychotic depression in which there are associated features which link illness with schizophrenia. There may be some degree of depersonalization or of unreality feelings. Depression here is also associated with loss but the loss is of a more obscure kind than is the case with reactive depression and derives from an earlier date in the development of the individual. For example, the loss might be that of certain aspects of the mouth which disappear from the infant's point of view along with the mother and the breast when there is a separation at a date earlier than that at which the infant had reached a stage of emotional development which would provide the infant with the equipment for dealing with loss. The same loss of the mother a few months later would be a loss of object without this added element of a loss of part of the subject.

It is necessary therefore to categorize two forms of depression: *reactive depression* and *schizoid depression.* In extreme cases of the latter the clinical picture resembles that of schizophrenia, and in fact there can be no clear line of demarcation between any form of mental illness and the other forms. And in an individual's illness any kind of mixture and alternation must be expected. And alternations occur in one individual between a psycho-neurotic manifestation and a more psychotic illness (e.g. obsessional neurosis breaking down into a phase of agitated depression, and recovering to obsessional neurosis, etc.). For mental illnesses are not diseases like phthisis, or rheumatic fever, or scurvy. They are patterns of compromise between success and failure in the state of the individual's emotional development. Thus health is emotional maturity, maturity at age; and mental ill-health always has behind it a hold-up of emotional development. The tendency towards maturation persists, and it is this that provides the drive towards cure, and towards self-cure if no help is available. It is this that is at the back of the *process* that can be relied on to appear if there can be provided a facilitating environment, nicely adjusted to the immediate needs of the person's maturational stage. It is here that the social worker becomes involved in a constructive way, and in fact the social worker has power that is not available to the psycho-analyst in so far as the latter is confining his work to interpreting the nascent conscious elements in the transference neurosis, appropriate in the treatment of psycho-neurosis.

Let me emphasize the point that mental illnesses are not diseases; they are compromises between the individual's immaturity and the actual social reactions, both helpful and avenging. In this way the clinical picture of a mentally-ill person varies

according to the environmental attitude, even when the illness in the patient remains fundamentally unaltered; for example, a thirteen-year-old girl was dying at home, through refusing food, but normal and even happy in an alternative environment.

At the end of the scale beyond schizoid depression is schizophrenia proper. Here the accent is on certain failures of personality construction. These will be listed, but first it must be made clear that clinically there may be a normally functioning area of the personality even in a severe schizoid case, so that the unwary may be deceived. This complication will be dealt with below under the term false self.

To understand schizophrenia-type illness it is necessary to examine the maturational processes as they carry the infant and the small child along in the early stages of emotional development. In this early time, when so much development is starting and nothing is being completed, the two trends are described by the words *maturation* and *dependence*. The environment is essential and gradually becomes less essential, so that one could speak of double dependence, changing into simple dependence.

The environment does not make the infant grow, nor does it determine the direction of growth. The environment, when good enough, facilitates the maturational process. For this to happen the environmental provision in an extremely subtle manner adapts itself to the changing needs arising out of the fact of maturation. Such subtle adaptation to changing need can only be given by a person, and one who has for the time being no other preoccupation, and who is 'identified with the infant' so that the infant's needs are sensed and met, as by a natural process.

In a facilitating environment the infant person is engaged in making various grades, three of which can be described as:

Integration
Personalization
Object-relating

Integration rapidly becomes complex, and soon includes the concept of time. The reverse process is that of disintegration, and this is a word used to describe a type of mental illness: disintegration of the personality. In lesser degree the reverse of integration is splitting, and it is this feature, splitting, that characterizes schizophrenia, hence its name.

Personalization is a word that can be used to describe the achievement of a close relationship between the psyche and the body. Freud said that the ego is essentially built up on a basis of

body-functioning; the ego is essentially a body-ego (that is to say, not a matter of the intellect). In the present context we are looking at the achievement in each individual person of the linkage of psyche and soma. Psycho-somatic disease is sometimes little more than a stressing of this psycho-somatic link in face of a danger of a breaking of the link; this breaking of the link results in various clinical states which receive the name 'depersonalization'. Here again, the reverse of the development that we see in the dependent infant is a state that we recognize as a mental illness, namely depersonalization, or psycho-somatic disorder hiding this.

The same will be found if we examine object-relating, and the instinctual life. The infant becomes able to relate to an object and to join up the idea of the object with a perception of the whole person of the mother. This capacity to relate to an object develops only as a result of a maternal adaptation that is good enough; the theory of this is complex and I have tried to describe its complexity elsewhere (Winnicott, 1951). This capacity cannot develop by maturational process alone; the good-enough adaptation of the mother is essential, and this must last over a long enough period, and a capacity for relating to objects can be lost, in part or wholly. At first the relationship is to a subjective object, and it is a long journey from here to the development and establishment of a capacity to relate to an object that is objectively perceived and that is allowed a separate existence, an existence outside the omnipotent control of the individual.

Success in this field of development is closely linked with the person's capacity to feel real; this, however, has to be brought into line with the idea of feeling real in the world and feeling that the world is real. It has to be acknowledged that the normal person cannot achieve a feeling of reality in the world comparable with the schizophrenic's feeling of reality in the absolutely private world of the schizophrenic's relation to subjective objects. For normal persons the only approach that can be made to this quality of feeling is in the cultural field. The opposite to the maturational trend towards object-relating is de-realization and loss of contact with (shared) reality, and here again are words that describe mental illness.

Added to all this there is a whole category of illness, paranoia and the persecutory elements that may complicate depression, and which, when contained within the personality, bring about the state of hypochondria. It is not possible to include a description of this here, because paranoia is not an illness in itself, but it is a complication of either depression or schizophrenia. In

the last analysis the origin of the persecutory elements that complicate depressive illness takes the patient and the analyst to oral sadism that has not been accepted by the individual, along with its results in the patient's imaginative concept of the psychosomatic self. But there can be a deeper origin to paranoia, which may be associated with integration and the establishment of a unit self: I AM.

Here could be brought in the concept of the true and the false self. It is essential to include this concept in the attempt to understand the deceptive clinical picture presented in most cases of schizophrenic-type illness. What is presented is a false self, adapted to the expectations of various layers of the individual's environment. In effect the compliant or false self is a pathological version of that which is called in health the polite, socially adapted aspect of the healthy personality. (I have described elsewhere (Winnicott, 1952) the point of origin of the false self, in relation to a not-quite-good-enough adaptation in the process in the infant of relating to objects.

In the pathological form of this the individual eventually destroys the false self, and attempts to reassert a true self, although this may not be compatible with living in the world, or with life. A mental breakdown is often a 'healthy' sign in that it implies a capacity of the individual to use an environment that has become available in order to re-establish an existence on a basis that feels real. Naturally such a device does not by any means always succeed, and it is very puzzling to society to see a compliant and perhaps valuable false self destroy good prospects by a renunciation of every obvious advantage simply for the hidden advantage of gaining a feeling of reality.

One other type of illness, psychopathy, must be described. In order to do this it is necessary to get on to another track and to look at the emotional growth of the individual in terms of dependence.

It will be observed that there is no place, in my way of stating these matters, for a mental illness that is not related to a developmental immaturity, perhaps with distortions due to the attempt of the individual to use the environment for the purpose of self-cure.

In terms of dependence it can be stated that there are for comparison two extremes and an area in between. At one extreme, *where dependence is adequately met*, the child achieves interpersonal relationships as between whole people, and is healthy or mature enough to suffer from, and to deal with, the conflicts that are personal and that belong to the individual's own psychic reality,

or that are in the person's own inner world. Illness here is called psycho-neurosis and is measured by the degree of rigidity of the personal defences organized to deal with anxiety in the personal dream.

At the other extreme is mental illness of mental hospital type, psychosis, that is aetiologically linked with environmental failure, failure to facilitate the maturational processes, at the stage of double dependence. The term double dependence implies that the essential provision was completely outside the perception and comprehension of the infant at the time. Failure here is called *privation.*

In between is failure on top of success, failure of the environment that was perceived by the child as such at the time that the failure occurred. For such a child there was good-enough environmental provision, and then this stopped. The going-on-living that belonged to taking for granted a good-enough environment became replaced by a reaction to environmental failure, and this reaction broke up the sense of going-on-living. The name given to this state of affairs is *deprivation.*

This is the point of origin of the antisocial tendency, and here begins that which takes hold of the child whenever he or she feels hopeful, and compels activity that is antisocial until someone acknowledges and attempts to correct the failure of the environment. A failure really did happen in the child's history and there really was a significant maladjustment to the child's essential needs. Ironically, the child who is compelled to state and restate this claim on society is called maladjusted.

This antisocial tendency is naturally very common in its minor manifestations, since to some extent parents must fail to meet even essential needs often; but these minor failures of adjustment are corrected by the parents with the child living a home life in the family. The more serious examples of letting a child down (failure of ego-support), however, give the child an antisocial tendency and lead to character disorder and to delinquency. When the defences have become hardened and disillusionment is complete the child who has been affected in this way is destined to be a psychopath, specializing in violence or theft or in both together; and the skill that goes into the antisocial act provides secondary gains, with the result that the child loses the drive to become normal. But in many cases, had treatment been given at an early stage, before secondary gains had complicated matters, it would have been possible to find in the manifestations of the child's antisocial tendency an S.O.S. to society to acknowledge its debt and to re-establish for the child an environment in which

impulsive action was once more safe and acceptable, as it had been before the environmental maladjustment.

The field of psychiatry having been covered in this psychological way, in terms of the emotional development of the individual, it is possible for me to pass over to a description of mental illness in terms of response to help. We need to acknowledge that there are cases that are outside remedy. We may die straining to give help where help cannot be given. Apart from this, I do know that psychiatrists and psycho-analysts constantly hand over cases to the care of the psychiatric social worker for no better reason than that they can do nothing themselves. I do this. What sense does it make?

Well, in my view, there are reasons why you might accept the position as it is. First I would call attention to Clare Winnicott's (1962) statement of agency function. For instance, the fact that you represent the Mental Health Act, or the Home Office, or society's genuine concern in regard to its deprived children, really does put you in a position that is unique in each case. This gives you special scope, especially in respect of the mentally ill who are not psycho-neurotic and in respect of the early cases displaying an antisocial tendency.

Your function can logically be reviewed in terms of infant-care, that is in terms of the facilitating environment, the facilitation of maturational processes. Integration is vitally important in this connexion, and your work is quite largely counteracting disintegrating forces in individuals and in families and in localized social groups.

I think of each social worker as a therapist, but not as the kind of therapist who makes the correct and well-timed interpretation that elucidates the transference neurosis. Do this if you like, but your more important function is therapy of the kind that is always being carried on by parents in correction of relative failures in environmental provision. What do such parents do? They exaggerate some parental function and keep it up for a length of time, in fact until the child has used it up and is ready to be released from special care. Special care becomes irksome once the need for it has passed.

For instance, think of casework as providing a human basket. Clients put all their eggs into one basket which is you (and your agency). They take a risk, and first they must test you to see if you may be able to prove sensitive and reliable or whether you have it in you to repeat the traumatic experiences of their past. In a sense you are a frying-pan, with the frying process played backwards, so that you really do unscramble the scrambled eggs.

Infant-care can almost be described in terms of holding, holding that starts off immensely simple and that steadily becomes extremely complex, yet remains, just the same, a holding. In other words, social work is based on the environmental provision that facilitates the individual's maturational process. It is simple and at the same time it is as complex as this environmental provision rapidly becomes in infant- and child-care. It is even more complex because it continues the provision to cover family care and the care of the small social unit. Always it has as its aim not a directing of the individual's life or development, but an enabling of the tendencies that are at work within the individual, leading to a natural evolution based on growth. It is emotional growth that has been delayed and perhaps distorted, and under proper conditions the forces that would have led to growth now lead to a disentanglement of the knot.

One of the difficulties you encounter may be singled out for special consideration. I refer to the clients who become clinically ill *because they find in you and your care the environment which is reliable*, and which, for them, practically invites a mental breakdown. In the area of delinquency (antisocial tendency related to deprivation) this means that when the client gains confidence in you there comes stealing, or destruction that uses your capacity to act strongly, backed by your agency. In the area of madness, what happens is that your client uses your special provision in order to become disintegrated or uncontrolled or dependent in the way that belongs to the period of infancy (regression to dependence). The client goes mad.

This has the germ of healing in it. It is a process of self-cure that needs your help; and in some cases it works. It is relaxation that is not possible except in the setting you have shown you can provide, in a limited professional area. All the same, you may find this difficult to distinguish from the willy-nilly breakdowns of those who cannot wait for good conditions but who simply fail to maintain the integration and emotional growth which they have attained or have seemed to have attained. Usually it is not impossible to make the distinction.

You will see why it is that I spoke first of psycho-neurosis and the repressed unconscious. On the whole repression is not relieved by environmental provision, however skilled and constant. Here the psycho-analyst is needed.

However, the more psychotic or insane disorders are formed in relation to failures in environmental provision, and they can be treated, sometimes successfully, by new environmental provision and this may be your psychiatric social work, casework. What

you find yourself providing in your work can be described in the following ways:

You apply yourself to the case.
You get to know what it feels like to be your client.
You become *reliable* for the limited field of your professional responsibility.
You behave yourself professionally.
You concern yourself with your client's problem.
You accept being in the position of a subjective object in the client's life, while at the same time you keep both your feet on your ground.
You accept love, and even the in-love state, without flinching and without acting-out your response.
You accept hate and meet it with strength rather than with revenge.
You tolerate your client's illogicality, unreliability, suspicion, muddle, fecklessness, meanness, etc. etc., and recognize all these unpleasantnesses as symptoms of distress. (In private life these same things would make you keep at a distance.)
You are not frightened, nor do you become overcome with guilt-feelings when your client goes mad, disintegrates, runs out in the street in a nightdress, attempts suicide and perhaps succeeds. If murder threatens you call in the police to help not only yourself but also the client. In all these emergencies you recognize the client's call for help, or a cry of despair because of loss of hope of help.

In all these respects you are, in your limited professional area, a person deeply involved in feeling, yet at the same time detached in that you know that you have no responsibility for the fact of your client's illness, and you know the limits of your powers to alter a crisis situation. If you can hold the situation together the possibility is that the crisis will resolve itself, and then it will be because of you that a result is achieved.

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PSYCHIATRIC DISORDER IN TERMS OF INFANTILE MATURATIONAL PROCESSES[1]

(1963)

My aim is to follow up the main trend in Freud's general thesis, that for the aetiology of psycho-neurosis we must look to the Oedipus complex, and therefore to the interpersonal relationships as between three persons belonging to the child's toddler age. I do thoroughly believe in this theory. I have worked on the basis of this theory for forty years, and I believe, as most psychoanalysts do, that the training in the psycho-analytic technique should be done in respect of cases that can be treated by classical technique, that is, a technique devised for precisely this: the analysis of the psycho-neurotic.

As supervisors of students we find ourselves at our best when the student analyst has a good case, and indeed good analysis can only be done on a good case. If the case is not good (psychoneurotic) we cannot tell whether the student is doing well or badly in his or her effort to learn the basic technique of our craft.

Types of Case Available

We all know, however, that in our practical work, once we are qualified as analysts, we cannot restrict our work to the analysis of psycho-neurotics. To start with, as our work gets deeper and more thorough we discover the psychotic (may I use the word?) elements in our psycho-neurotic patients. To jump ahead with my thesis, the pregenital fixations of our psycho-neurotic patients turn out sometimes to be there in their own right, not simply as regressive phenomena organized in defence on account of anxieties belonging to the Oedipus complex proper.

We cannot always make a correct diagnosis at the beginning. Some reactive depressions turn out to be more severe than we could have guessed; especially does hysteria tend eventually to show psychotic features as analysis proceeds. And there is the very real bugbear of the as-if personality—that which I person-

[1] Dorothy Head Memorial Lecture given to the Philadelphia Psychiatric Society at the Institute of the Pennsylvania Hospital, Philadelphia, October 1963.

ally call the *False Self*, which presents well to the world, but our treatment must get behind it to the breakdown that is negated. In these False Self cases our treatment makes successful people ill, and sometimes we just have to leave them ill; who is to know that without us they would not have been worse—perhaps would have killed themselves or perhaps would have become even more successful but more and more unreal to themselves. And then it also happens that as psychotherapists we get asked to treat frankly psychotic persons, and we may accept them as research cases. But what do we do? Can we apply the psycho-analytic technique?

Wider Application of Psycho-Analytic Technique

I personally believe we can, provided that we accept a change in the theory of the aetiology of the disorder. We shall not always produce cures, but at any rate we shall be able to feel we are doing honest work.

The Deepening of Interpretative Work

There is a very big complication which I must surmount if I am to present my view in a brief statement, and this is that it is possible to do deeper and deeper work using the classical technique, by knowing more and more about mental mechanisms and applying this knowledge. I could talk just simply about this extension of psycho-analytic work but instead I wish to explain what I mean.

Classical psycho-analysis can be done on a well-chosen psychoneurotic case simply by the interpretation of ambivalence as and when it turns up in the transference neurosis. (This type of case is getting rare, at any rate in England, because it seems that patients have already done this work on themselves through reading and through absorbing the general cultural trend, as expressed openly and in novels and plays and in the modern reassessment of the old masters (Shakespeare, Leonardo da Vinci, Beethoven, etc. etc.).)

Then comes the analysis of depression. By diagnosing depression we are taking for granted ego organization and strength. The analysis of depression involves an understanding of the mental mechanisms of introjection, and the theory of an inner psychic reality, localized (in the patient's fantasy) in the belly or in the head, or in some way or other within the self. The lost object is taken into this inside place and there subjected to hate, till hate is expended; and recovery from mourning or depression takes place, spontaneously in mourning and often spontaneously in

reactive depression. This extension of theory leads in practice to developments that arise out of the study of the world of inner phenomena. And the end of a depression may come as the passage of a dark faecal lump, or by surgical removal of a tumour, or in some dream form that reaches to this in symbolic form.

Personal Psychic Reality Located Inside

Analysis of depression and hypochondria leads then to an extension based on the study of the whole body functioning, including that of the bowels, and introjection and projection become mental mechanisms that originate as elaborations of ingestion and elimination.

Freud, Abraham and Klein opened up a new world here for the practising analyst. The technique of analysis was not affected.

The analyst is now involved in a study of not only hate and aggression, but also of the results of these in the patient's inner psychic reality. These results can be labelled as benign and persecutory elements, that need management in this unget-at-able inside world, and in fact the mood depression becomes a clinical feature indicating a temporary blanketing of all inner phenomena; recovery from depression becomes a carefully controlled lifting of the fog, where here and there in the inner world benign and persecutory elements can be safely allowed to meet and contend.

Projection and Introjection Mechanisms

Now a new area for interpretative work is opened up because of the interchange of the elements that accrue in the inner psychic reality and in the external (or shared) reality. This forms an important aspect of the individual's relationship to the world, and has to be accepted as comparable in importance with the object relationships that have id-functioning as their basis.

Moreover the clinical alternative between hypochondria and delusions of persecutory factors becomes manageable as a concept, representing introjected and projected forms of the same thing, namely, the attempt to control and the failure to control the persecutory elements in the personal inner world of the individual.

From here the analyst, keeping within the classical technique, finds he can interpret the way benign and persecutory internal factors depend for their origin on instinctual experiences in their satisfactory and unsatisfactory aspects respectively.

Relating to Objects

In the same way the analyst goes deeper in his interpretations of the individual's relating to objects. There are primitive aspects of such relating, and these include a splitting of the object, so that ambivalence is avoided, and also splitting in the personality itself to match the splitting of the object. Also relating with instinctual drive to a part-object, or what cannot be conceived of except as a part-object, gives rise to crude talion fears, which make the individual withdraw from relating to objects. All these things can be seen in analytic material, and especially when the patient is dealing with psychotic material and is a 'borderline' case.

It is necessary to try to get all these things into the scope of one's understanding, using the classical analytic technique, so that interpretation may be made if the patient is ready for interpretations of this kind.

The State of the Patient's Ego

At this stage in my exposition you may be feeling, as clinicians, some kind of a strain. I hope you are, because there is a reason for this that can be given.

At this point the question does arise: *in what state is the patient's ego? What dependence is there on ego-support?* How can the analyst know what degree of intellectual—rather than feeling—response will be evoked by interpretations of this kind at a particular moment? If the interpretation is incomprehensible then, whatever the reason, the patient feels hopeless, and may feel attacked, destroyed and even annihilated.

From here we go on to a study of ego psychology, to an assessment of the ego-structuring and ego-strength or rigidity or flexibility, and of ego-dependence.

The Infant in Care

It may be that in analysis of borderline cases we can interpret in a way that could be called deeper and deeper, but in doing so we are becoming more and more divorced from the state of affairs of the patient as an infant. For an infant is an infant in care, a dependent being, absolutely dependent at first; and it is not possible to talk about an infant without at the same time talking about infant-care and the mother.

Infant-care and Mental Health

This leads directly to my main point, which is that *I think we follow Freud when we make a direct link between early infancy* (that is,

the infant in care, in a state of absolute dependence) *and the more primitive psychiatric disorders*, those grouped under the word schizophrenia. The aetiology of the schizophrenic takes us back not to the Oedipus complex (which was never properly or wholly reached) but to the two-body relationship, the relationship of the infant to the mother before father or any other third body came on the scene.

In fact, we come to the life of the infant related to part-objects, and the infant who is dependent but not able to know about dependence. The mental health of the individual in respect of freedom from psychotic illness is being laid down by the infant and mother together in the very early stages of infant growth and infant-care.

The Ego in Infancy

What are the main things that take place in the emotional growth of the infant in the early weeks and months (consolidated at later stages)?

Three of these are: Integration
Personalization
Relating to objects.

The ego of the infant is very strong, but only so because of the ego-support given by a good-enough mother who is able to throw her whole self into adapting to the needs of her infant, gradually withdrawing from this position as the infant needs her to adapt less and less closely. Without this ego-support the infant's ego is unformed, weak, easily disrupted, and incapable of making growth along the lines of the maturational process.

The Nature of Psychiatric Disorder

Psychiatric illness is commonly described in language that indicates specific failures on the part of the patient to establish these and other infantile positions. Personalities become 'disintegrated', patients 'lose the capacity to dwell in their bodies' and to accept their skin-boundary, and patients become 'unable to relate to objects'. They 'feel unreal' in relation to the environment and they 'feel that the environment is unreal'.

The point is: how far do psychiatrists feel it is a fair statement that the disorders they are dealing with are relative failures exactly where achievements characterize the life of every healthy infant?

Sources of My Personal Ideas

This way of looking at development derives from a confluence of several types of experience. For my part, I have had much opportunity as a paediatrician to observe infants with their mothers, and have made a point of getting innumerable mothers to describe their infants' way of life in the early stages before the mother has got out of touch with these intimate things. (If I had my time again I would work with premature infants, but this has not been possible.) Then I have had a personal analysis which took me back into the forgotten territory of my own infancy. This was followed by the psycho-analytic training, and my basic training cases took me to early infantile mental mechanisms as displayed in dreams and in symptoms. Child analysis gave me a child's view of infancy.

Then I came to the analysis of patients who proved to be borderline, or who came to have the mad part of them met and altered. It is work with borderline patients that has taken me (whether I have liked it or not) to the early human condition, and here I mean to the early life of the individual rather than to the mental mechanisms of earliest infancy.

Clinical Illustration

(The characteristic of the Monday session, the one before the session that I am reporting for discussion, was that my young female patient came loaded up with groceries. She had discovered the shops near my consulting room, and she was delighted with them. This was a natural development of her gradual discovery of the relationship to me in the transference of what she calls her greed. She has even said that coming to analysis is coming to a meal. There has been a long preparation for this in reports of her anorexia which alternates with an extreme degree of libidinization of a really good well-cooked and well-served meal.)

On Tuesday Miss X lay on the couch and, as usual, covered herself with the rug from neck to toe, and lay on her side facing me. (I sit, in her analysis, at the side, but at the level of the cushions.) Nothing happened. She was not anxious, nor was I. We talked about a few things in a desultory manner, but there was no development of any theme. At the end Miss X was contented to go, and she had enjoyed her session.

This is an analysis with a very steady development in the analytic process, and I was by no means at sea, although I did not and could not know exactly what was happening.

The next day, Wednesday, Miss X covered herself over as

usual, and this day she talked a lot, half apologizing that there seemed to be no material for analysis. We had a conversation about horse-jumping, and as it happened we had each watched the same horse-jumping competition on TV. I took part naturally in the conversation, not knowing what was going on. She said that the English just let the horse jump, and when there is success, as there often is, it's just that the horse is a very good one. The Germans, on the other hand, calculate everything, including the number of steps the horse will need to take before each hurdle. In the end it emerged that what impressed her most in horse-jumping was the training of the horses.

Now, I pricked up my ears here, because I know that Miss X has a vested interest in the training of analysts. She had several years with one before finding out that he wasn't trained, and she did a great deal of reading before risking a second analysis, and choosing me. I found that she had read me pretty thoroughly, and once she had decided on me she had waited a considerable time rather than go to anyone else.

So now the session was three-quarters through, and the work was done in the last few minutes, as often happens in her case.

She now reported a dream about a painter whose work she had told me about a week earlier. His paintings are very good indeed and he is not recognized yet. In the dream she went to buy a picture, perhaps one of those she saw in the original exhibition, but he had now painted many pictures, and had changed. His original pictures were like those of a child. She would rather buy a child's picture. But all the later pictures were calculated and sophisticated and the artist couldn't even remember the original pictures. She even drew one of them but he couldn't remember.

When I said that this dream continued the theme of the technique for horse-jumping, and the matter of training and loss of spontaneity, she immediately saw that this was so, and she was pleased. She elaborated the theme. It was a question of the early promise and the practical technique producing a finished product.

This opened up the whole idea of yesterday's session which she went on to say had been important and indeed crucial. In the evening she had been thinking about it, and she now remembered. This was how it was.

In the previous analysis she had quickly reached to the point where she is with me now in this analysis. However, the previous analyst could not let things develop. When she lay quiet, for instance, he might tell her to sit up, or he might adopt some other

procedure, and she quickly lost touch with the process that had started up in her. It took some years for her to recognize that it was the analyst's technique that was not suitable for her type of case, and eventually she discovered that he was not a trained analyst. And if he had been a trained analyst he might not have been able to meet her needs which were those of a psychotic patient (this in spite of the fact that she is not as ill as many schizophrenics she had known and lived with and tried to help).

In the quiet session yesterday she had reached to this point and had got through a difficulty. On the one hand she would be relieved to find that her analysis with me, which also started well, would fail too; that would be too bad, and it would end in suicide, but that is what she knows about from experience, and she can become numb and avoid pain in experiencing this which is what she expects. She can even feel power here by knowing the truth in advance.

What took place in the hour was that she came to know that the analysis was not going to fail in the usual way, and that she would go ahead and take all the risks and let feelings develop, and perhaps suffer deeply. In this way she found this Tuesday hour extremely satisfying, and she felt grateful.

She now went on to do what she sometimes does and can do because of her special insight, and she gave me a useful hint about the analyst's role in the treatment of patients whose fear is of disintegration. She pointed out that such patients absolutely need the analyst to be omnipotent. Here they are unlike psychoneurotics. They need the analyst to know and to tell them what they fear. They themselves know all the time, but the thing is that the analyst must know and say it. The patient may say and do things to put the analyst off the scent, in a further test of his ability to see the main point without being told.

Together we added the explanation that it is the patient's own omnipotence and omniscience that the analyst must take over so that the patient may with relief break down, break up, and experience the worse degree of disintegration or sense of annihilation.

As a corollary, a schizoid patient is gullible. Anyone may come along, a quack, a faith-healer, a wild analyst—he (or she) has only to say: I know what you are like and I can cure you, and the patient must fall for it. This is the first phase, and the person who says this may be wholly untrained and in fact may be an ignorant fool, or a charlatan. Then comes the testing, and the patient's disillusionment and withdrawal to a new hopelessness, which is so familiar that it is almost welcomed. To get the patient

through to the next phase the analyst must be trained or must have a structured theory and a mature personality and a steady attitude towards the patient and the treatment. Some analysts may not like this aspect of their work because what is not called for is cleverness.

The next day, Thursday, Miss X came a quarter of an hour late, a very rare thing in her analysis. The car had not come in time, but Miss X said this was not a satisfactory explanation because she had dreamed that she was late for today's session. I interpreted here that something had changed so that she now showed ambivalence in her relation to me and the analysis. She agreed and said that in fact she was especially eager to come because she felt very pleased indeed with the last few days' analysis. Obviously there must be some other factor going counter to her wish to come.

What happened in the hour was a new statement of the difficulties ahead. It would be found that she could be exceedingly greedy. We discussed this, and I interpreted that this meant that there exists a compulsive element in her appetite. (We have already done work on this.) What she knows will be difficult will be for me to manage the analysis when she reaches to her full capacity to lay claim to me and all that is mine. Stealing comes in here, and on Monday, I remembered, she had borrowed a book.

On the other hand, and I pointed this out, she had yesterday paid me on the spot by giving me a useful hint on the analyst's role in the analysis of schizoid patients.

We had plenty of material available that had to do with eating the analyst (the grocer's shop, etc.) and I was glad I had not interpreted oral sadism in these earlier stages because the significant interpretation, now becoming acceptable, was of the compulsive greed of the antisocial tendency. This relates to deprivation.

The Dependent Infant

Reformulating the infancy experience I find I must speak in terms of dependence, and in fact I am now suspicious of all statements about early mental mechanisms that do not take into account the infant caught up in the behaviour and attitude of the mother.

The Inherited Tendencies

This brings me to a statement of early infancy. In infancy the

growth-process belongs to the infant, and is the sum of inherited tendencies, and this includes the *maturational process*. The maturational process only takes effect in an individual infant in so far as there is a *facilitating environment*. The study of the facilitating environment is almost as important at the beginning as the study of the individual maturational process. The characteristic of the maturational process is the drive towards *integration*, which comes to mean something more and more complex as the infant grows. The characteristic of the facilitating environment is *adaptation*, starting almost at 100 per cent and turning in graduated doses towards de-adaptation according to the new developments in the infant which are part of the gradual change towards independence.

When the facilitating environment is good enough (this always means that there is a mother who is at first given over to her job of infant-care, gradually, and only gradually, reasserting herself as an independent person) then the maturational process has its chance. The result is that the infant personality achieves some degree of integration, at first under the umbrella of ego-support (the mother's adaptation) and in time more and more an achievement that stands on its own legs.

As I have said, in the course of these early weeks, months, years, the infant also becomes able to relate to objects, becomes a dweller in his own body and body-functioning, and experiences an I AM feeling, and is ready to meet all-comers.

These developments in the individual that are based on the maturational processes constitute mental health. It is to the opposite or the reversal of these same processes that we must look if we are to understand personality disturbance of schizoid kind.

Modifications of Technique

The important thing left over for me to describe is the modification of technique needed when it is a borderline case that is being treated. The basis of the treatment is the classical technique, but things taken for granted in psycho-analysis of the psycho-neurotic become the cornerstone of the modified technique.

In psycho-analysis the setting is taken for granted. The analyst behaves himself, gives himself over to the patient's interests in the analytic hour, ignores all but the essentials which are the details of the transference neurosis. He believes in the patient, and when there are deceptions he believes in the motives the patient has for deceiving the analyst.

When the psycho-neurotic patient refers to these matters the

analyst knows he or she is finding in the analytic setting reliable elements that have already been experienced in the past. The psycho-neurotic has a capacity to believe in the analysis based on experience, and his suspicions are due to his ambivalences.

What has been said here of psycho-neurotics is also true of the depressives, except in so far as these have schizoid characteristics included in them.

When a psycho-analyst is working with schizoid persons (call it psycho-analysis or not) the insightful interpretation becomes less important, and the maintenance of an ego-adaptive setting is essential, The reliability of the setting is a primary experience, not something remembered and re-enacted in the analyst's technique.

The Risks of Dependence

Dependence takes on a form that is exactly like that of the infant in the infant-mother relationship, only the patient may take a long time to get there because of all the tests that have to be made by the patient who has become wary because of previous experiences. It is, one can well understand, very painful to the patient to be dependent unless one is actually an infant, and the risks that have to be taken in regression to dependence are very great indeed. The risk is not that the analyst will die so much as that the analyst will suddenly be unable to believe in the reality and the intensity of the patient's primitive anxiety, a fear of disintegration, or of annihilation, or of falling for ever and ever.

The Holding Function

You will see that the analyst is *holding* the patient, and this often takes the form of conveying in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced, or that is waiting to be experienced. Occasionally holding must take a physical form, but I think this is only because there is a delay in the analyst's understanding which he can use for verbalizing what is afoot.

There are times when you carry round your child who has earache. Soothing words are no use. Probably there are times when a psychotic patient needs physical holding, but eventually it will be understanding and empathy that will be necessary.

Techniques Compared

With the *psycho-neurotic* case the analyst must interpret love

and hate as it appears in the transference neurosis, and this means taking what is going on back to childhood. This concerns the patient's relating to objects.

With the *depressive* case the analyst must survive the aggression that goes with loving. Reactive depression is much like psychoneurosis and needs interpretation of the transference. But depression needs the survival of the analyst, and this gives the patient time to reassemble the elements in his or her inner reality so that the inner analyst also survives. This is a task that can be done since *depression implies ego-strength*, and our diagnosis of depression implies that we think that the patient can cope with guilt and ambivalence and accept personal aggressive drives without disruption of the personality, given time.

In treatment of *schizoid* persons the analyst needs to know all about the interpretations that might be made on the material presented, but he must be able to refrain from being sidetracked into doing this work that is inappropriate because the main need is for an unclever ego-support, or a holding. This 'holding', like the task of the mother in infant-care, acknowledges tacitly the tendency of the patient to disintegrate, to cease to exist, to fall for ever.

Adaptation and the Satisfaction of Id-drives

A source of misunderstanding here is the idea (that some analysts have) that the term 'adaptation to need' in treatment of schizoid patients and in infant-care means meeting id-drives. In this setting it is not a question of meeting id-drives or of frustrating id-drives. There are more important things going on, and these are of the nature of giving ego-support to ego processes. It is only under conditions of ego adequacy that id-drives, whether satisfied or frustrated, become experiences of the individual.

Summary

The processes that constitute schizophrenic mental illness are the processes of early infantile maturation, but in reverse.

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HOSPITAL CARE SUPPLEMENTING INTENSIVE PSYCHOTHERAPY IN ADOLESCENCE[1]

(1963)

Adolescence, which means becoming an adult, is a phase in healthy growth. It covers the period of the individual's puberty. It also includes the socialization of the boy or girl. Here, the word socialization does not mean adaptation and conformity. When in health the individual becomes a mature adult, this implies that he or she is able to identify with parent-figures and with some aspect of society without too great a sacrifice of personal impulse, or alternatively, be essentially himself or herself without needing to be antisocial. In health the boy or girl becomes able to take responsibility, and to help to maintain, or modify, or even to alter completely the legacy of the last generation. Inevitably he and she will eventually, as adults, hand on a legacy to the next generation in the eternal series.

Adolescence, then, is a phase in the growth-process of every boy or girl. In our theoretical considerations and practical work we have to keep this in mind while we are dealing with that other thing: psychiatric illness in a boy or girl who happens to be in the age group of the adolescent or young adult.

Sketch of Adolescence

Adolescence itself can be a stormy time. Defiance mixed with dependence, even at times extreme dependence, makes the picture of adolescence seem mad and muddled. Parents, who are much needed over this phase, find themselves confused as to their role. They may find themselves paying out dollars to enable their own children to flout them. Or they may find themselves being necessary as people to be wasted, while the adolescent goes for friendship and advice to aunts and uncles and even to strangers. Where the family is absent or ill some aspect

[1] Lecture given at The McLean Hospital, Belmont, Massachusetts, U.S.A., as part of a Clinical Symposium: 'The Individual and the Community: Current Perspectives in Rehabilitation', on the occasion of the formal opening of the new Rehabilitation Building, October 1963.

of society must take over the family function. On top of all this is the complication that adolescents have adult techniques at their command. The boy of four years, who is in the throes of Oedipus conflicts, dreams of his father's death, but now at fourteen he has the power to kill. Suicide is now possible. Drugs can be obtained. The girl, who at four years was identified with mother and also jealous of her mother's power to conceive, dreaming of burglars or of her mother's death, now at fourteen can become pregnant or may offer her body for money. The adolescent girl can become pregnant although not at the stage of wanting to give a baby to someone she loves or of wanting to devote herself to a baby's care. This is only to remind you, though you need no such reminder, that adolescence itself is no easy thing in the world of affairs (cf. Winnicott, 1962).

If it be agreed that the adolescent boy has a special problem with his aggressive drives (and so the girl, too, indirectly), it will be agreed also that the problem is altered for the worse by advances in thermonuclear physics. Most of us believe that there will be no sub-total wars since any war becomes total war and total war is unthinkable. We are here driven to an assessment of the value of war in its function of giving a licence to kill. I put 'value' in inverted commas, because I suppose everyone hates war and prays for peace; but as psychiatrists or social psychologists we are forced to measure the effect of permanent peace on the mental health of the community. The effect of the idea of permanent peace puts a severe strain on everything except emotional maturity, which is rather a rare achievement. Can adolescence in general gather all its aggression into the competitive or dangerous sport? Will not society clamp down on dangerous sport and make even this unrespectable or even anti-social? We do not know the answer to this broad question yet, but we do know that a localized war, with all its immense tragedy, used to do something positive for the relief of individual tensions, enabling paranoia to remain potential and giving a sense of REAL to persons who do not always feel real when peace reigns supreme. Especially in boys, violence feels real, while a life of ease brings a threat of depersonalization.

You will have given much thought to these problems that are inherent in the growing-up process, and you will have found ways of stating the important part that the child's own home can play if it is still a going concern. Your institution is in part an organized substitute for the home, which is often satisfactory enough and yet not quite able to stand the specific strain of caring for an ill member over a long period.

Continuing my sketch of adolescence, dogmatically stated for brevity's sake: there is only one cure for adolescence, and this is the passage of time and the passing on of the adolescent into the adult state. We must not try to cure adolescents as if they were suffering from a psychiatric disorder. I have used the phrase 'adolescent doldrums' to describe the few years in which each individual has no way out except to wait and to do this without awareness of what is going on. In this phase the child does not know whether he or she is homosexual, heterosexual or narcissistic. There is no established identity, and no certain way of life that shapes the future and makes sense of working for graduation exams. There is not yet a capacity to identify with parent figures without loss of personal identity.

Then again, the adolescent has a fierce intolerance of the false solution. We contribute something to the adolescent if we as adults offer no false solutions, but if instead we meet the localized challenges and deal with acute needs as they arise. We expect defiant independence to alternate with regression to dependence, and we hold on, playing for time instead of offering distractions and cures.

Illness during Adolescence

Naturally we find any and every disorder in this phase of development:

Psychoneurosis proper.
Hysteria, with some psychosis hidden away causing trouble but never showing up clearly as madness.
Affective disorders, with depression at the base. These include:
- Manic-depressive swings.
- Manic-defence (denial or negation of depression).
- Elation, and paranoid and hypochondriacal complications.
- The false-self personality that threatens to break down at the period of examinations.
- The schizoid group of disorders. These involve the undoing of integration and of the maturational processes generally. Clinical manifestations include lack of contact with reality, depersonalization, splitting, and loss of sense of identity.

We find ourselves dealing with these disorders in patients who are at the puberty period of growth and who are adolescent in so far as they can be. It is difficult to sort out the ill from the normal

at this stage; also it is difficult to know in these cases whether to offer treatment in terms of care and management or in terms of psychotherapy. Roughly speaking, we offer psychotherapy to those patients who feel a need for it, or who can easily be helped to see that psychotherapy is relevant; here we watch out for the moment when institutional care or special mental nursing becomes necessary, necessary because the treatment has enabled the patient to reach a point at which breaking down becomes constructive. For the others who have no insight we try to provide care or mental nursing, and expect regressive phenomena to appear eventually; and we may wait to be able to add psychotherapy in some cases.

If in this new hospital building the intention is to facilitate the interaction of care and psychotherapy, this is to be providing just exactly what is necessary and also just what is difficult to provide. Why difficult? Briefly: not only do the care- and the therapy-personnel become jealous of each other, each unable to see the other's value, but also some patients tend to foster a split between these two groups. There is often a reflection here of the tensions between the patient's parents, and we see in displaced form the patient's fear of allowing the parents to come together (in the unconscious fantasy system).

There is much that could be said about the management or care of boys and girls who have these various disorders. Let me choose to pick out one thing for special mention. *There will be suicides.* Management Committees must learn to reconcile themselves to suicides, to truancy, and the occasional maniacal outburst with something in it very like murder, and broken windows and destruction of things. Psychiatrists who are blackmailed by these disasters are unable to do what is best for the rest of the community in their care. And the same applies to the blackmail of the psychiatrist by the antisocial tendency in patients. Of course actual destruction is not helpful, and prevention of actual destruction or suicide is the aim; but it is *human* prevention that is needed, and mechanical restraint is not valuable. This means that there will be failures of prevention since human beings have human limits to what they can and are willing to do.

You will have noticed that I have left out of my rough classification one important grouping, namely, the antisocial tendency, which can lead a boy or girl to delinquency and eventually to recidivism.

The term 'antisocial tendency' has a use because it links this type of disorder with the normal, and with what it is at its

inception, a reaction to deprivation. This tendency can become a futile compulsion and the child is then to be labelled delinquent.

Here is a disorder that is not to be classified along with the psycho-neuroses and the affective disorders and with schizophrenia; and it is a disorder that links very easily with the disorders that are inherent in the adolescent growth syndrome. Special management problems belong to work in this area. Here the theme cannot be developed but the main idea is that the antisocial tendency in a child represents (unconscious) hope related to the mending of a deprivation trauma (Winnicott, 1956).

Interaction of Maturational and Pathological Processes

I now come to the great difficulty which confronts all who are engaged in preventive and curative work. At this phase of individual growth, it is surely very difficult to diagnose health and normality and to distinguish it from psychiatric disorder. Adolescence alters the shape of psychiatric illness.

Here are twenty adolescents. They are isolated personalities but they group together loosely because of common interests: pop singers, the twist, jazz, a way of dressing, a state of doldrums which it would be dishonest to try to avoid. On the fringe of any group there is a depressive boy or girl who attempts suicide. Now the whole group displays a depressed mood, and is 'with' the one who makes the attempt. Another breaks a glass window for no reason at all. Now all the group is with this one who breaks the glass window. Another, along with some who are nearby, breaks into a shop and steals some cigarettes, or does something that arouses the law's attention. Now all the group is with this law-breaker.

Yet it can be said that on the whole the boys and girls comprising this group will come through without suicide, without murder, without violence and without theft.

In other words, adolescents in the doldrums phase seem to me to use the ill individuals on the fringe of the group to give reality to their own potential symptomatology. Let me now give an example to illustrate the problems of diagnosis and management.

Note on the Case of a Boy

I will refer to the case of a boy first referred to me at the age of eight years. It was possible at that age to see in him an organized sense of grievance which dated from a phase in his early childhood management and was related to the continued severe mental illness of his mother. Therapy was attempted at that stage but it was not successful partly because of the mother's illness.

The boy was sent to me again at the age of fifteen. In consultation at this age he was able to give me a vital clue relating to his attacks of violence. In actual fact he had been in danger of attempting to kill his father. The enlightenment came in the form of a dream which he illustrated with a drawing. The drawing showed his hand reaching towards the hand of his girl friend. In between the two hands in the dream was a barrier made of glass. The violence that he feared had to do with an attempt to break through the barrier between him and the actual world, a barrier which became more real the more his instincts were involved in object-relating.

I referred this boy to a colleague who is in charge of a mental hospital and who admitted the boy with my diagnosis of schizophrenia. This boy was dealt with well in hospital and he soon managed to fit into the community. A notable thing was that he temporarily found asylum from his mother's severe mental illness. Undoubtedly the immediate change in this boy was chiefly due to his finding an alternative home, one however which could not last long. Soon after he had settled into the hospital he was able to sever his tie with his particular girl friend on whom he was excessively dependent. Before coming into hospital he had constantly been found weeping after interminable conversations with this girl, the telephone and the wires representing the same as the glass frame between himself and the girl in the dream. Because of the fact of the thing in between him and the girl he was able to feel the full intensity of his love and his dependence. This girl had been needed to displace the ill mother. He improved after he had given up his addiction to this girl friend and he became more easy with the other members of the group and with the staff.

It is here that the case of this boy seems apposite in an address given to this hospital[1] at this moment. It illustrates the difficulties. In hospital the boy was able to use the excellent occupational therapy and art therapy departments. He settled in to very creative and original work both in modelling and in painting. Everything he did had striking significance. So often psychotic and near-psychotic patients prove to be deeply rewarding when they undertake original work in one of the departments of rehabilitation. The trouble was that this boy improved so much and he so much enjoyed the new relationship to the world that he formed in this small community that the doctors altered his diagnosis. They decided now that he was hysterical and somewhat antisocial, and that the external factor of his home conditions

[1] The McLean Hospital, Belmont, Massachusetts, U.S.A.

was the chief cause of his being thought to be ill. The boy was therefore discharged but not before the physician had found a good school for him where the whole of the boy's difficulties were plainly set before the headmaster. After a few months at the new school the boy began to show again the symptoms for which he was sent into hospital; he became violent and destructive and was unable to settle down to work. The diagnosis of schizophrenia was now reapplied; he was quickly removed from the school and at present the parents are trying to deal with the difficult situation by arranging for him to have an unlimited journey round the world in the hope that by the time he gets back home he will have grown up out of his difficulties. By then he may of course have got into serious trouble, or even may have done harm to someone.

This unsuccessful case can be used to illustrate the fact that a successful rehabilitation department can alter the clinical picture and make it seem that a patient has got well so that the original diagnosis is lost sight of. You and the department here will be aware of these dangers and will not easily be deceived. You will not be deceived, for instance, by excellent artistic productions which can indeed denote potential health in the patient but which do not stand for health itself.

Summary

Some characteristics of adolescence have been sketched and the relationship has been discussed of these characteristics to the symptomatology of psychiatrically ill children at the age of puberty. A case is given that illustrates some of the difficulties that belong to the management of patients of this age-group, and to the provision of rehabilitation facilities such as these that are being formally initiated on the day of this meeting.

DEPENDENCE IN INFANT-CARE, IN CHILD-CARE, AND IN THE PSYCHO-ANALYTIC SETTING[1]

(1963)

There is nothing new in the idea of dependence, either in the early life of the individual or in the transference which develops force as a psycho-analytic treatment gets under way. What I feel may need restating from time to time is the relationship between these two examples of dependence.

I need not quote from Freud. Dependence of the patient on the analyst has always been known and fully acknowledged, and for instance shows in the reluctance of an analyst to take on a new patient within a month or two of a long summer holiday. The analyst rightly fears that the patient's reaction to the break will involve deep changes that are not yet available for analysis. I will start with a development of this theme.

A young woman patient had to wait for a few months before I could start, and then I could see her only once a week; then I gave her daily sessions just when I was due to go abroad for a month. The reaction to the analysis was positive and developments were rapid, and I found this independent young woman becoming, in her dreams, extremely dependent. In one dream she had a tortoise, but its shell was soft so that the animal was unprotected and would therefore certainly suffer. So in the dream she killed the tortoise to save it the intolerable pain that was coming to it. This was herself and indicated a suicide tendency, and it was to cure this tendency that she had come for treatment.

The trouble was that she had not yet had time in her analysis to deal with reactions to my going away, and so she had this suicidal dream, and clinically she became physically ill, though in an obscure way. Before I went I just had time, but only just, to enable her to feel a connexion between the physical reaction and my going away. My going away re-enacted a traumatic episode or series of episodes of her own babyhood. It was in one

[1] A paper read to the Boston Psychoanalytic Society, October 1962, and first published in the *Int. J. Psycho-Anal.*, **44**, pp. 339–44.

language as if I were holding her and then became preoccupied with some other matter so that she felt *annihilated.* This was her word for it. By killing herself she would gain control over being annihilated while dependent and vulnerable. In her healthy self and body, with all her strong urge to live, she has carried all her life the memory of having at some time had a total urge to die; and now the physical illness came as a localization in a bodily organ of this total urge to die. She felt helpless about this until I was able to interpret to her what was happening, whereupon she felt relief, and became able to let me go. Incidentally her physical illness became less of a threat and started to heal, partly of course because it was receiving appropriate treatment.

If illustration were needed this might show the danger of underestimating transference dependence. The amazing thing is that an interpretation can bring about a change, and one can only assume that understanding in a deep way and interpreting at the right moment is a form of reliable adaptation. In this case, for instance, the patient became able to cope with my absence because she felt (at one level) that she was now not being annihilated, but in a positive way was being kept in existence by having a reality as the object of my concern. A little later on, in more complete dependence, the verbal interpretation will not be enough, or may be dispensed with.

You will have observed that I could go in either of two directions, starting from such a fragment from an analysis. One direction would take us to the analysis of reaction to loss and so to the main part of that which we learn in our psycho-analytic training. The other direction takes us to that which I wish to discuss in this paper. This other direction takes me to the understanding we have in us that makes us know that we must avoid going away just after starting an analysis. It is an awareness of the vulnerability of the patient's ego, the opposite of ego-strength. In innumerable ways we meet our patient's needs because we know what the patient is feeling like, more or less, and we can find the equivalent of the patient in ourselves. What we have in ourselves we can project, and find in the patient. All this is done silently, and the patient usually remains unaware of what we do well, but becomes aware of the part we play when things go wrong. It is when we fail in these respects that the patient reacts to the unpredictable and suffers a break in the continuity of his going-on-being. I wish to take up this point in particular later on in this paper, in discussing Zetzel's Geneva Congress paper (1956).

My general objective is to relate dependence in the psycho-

analytic transference to dependence at various stages of infant- and child-development and care. You will see that I am involved in an attempt to evaluate the external factor. May I be allowed to do this without being thought to be going back on what psycho-analysis has stood for over the past forty years in child psychiatry. Psycho-analysis has stood for the personal factor, the mechanisms involved in individual emotional growth, the internal strains and stresses that lead to the individual's defence organization, and the view of psycho-neurotic illness as evidence of intrapsychic tension that is based on id-drives that threaten the individual ego. But here we return to ego vulnerability and therefore to dependence.

It is easy to see why it is that psycho-analysts have been reluctant to write about the environmental factor, since it has often been true that those who wished to ignore or deny the significance of the intrapsychic tensions chiefly stressed the bad external factor as a cause of illness in child psychiatry. However, psycho-analysis is now well established, and we can afford to examine the external factor both bad and good.

If we accept the idea of dependence, then we have already started to examine the external factor, and indeed when we say an analyst should be trained we are saying that an essential for orthodox psycho-analysis is an external factor, that is to say the *good-enough analyst.* All this is self-evident, yet I can still find those who *either* never mention this external factor as if it were really important, *or else* talk about it all the time, ignoring the internal factors in the process. As Zetzel said in a seminar recently: first Freud thought all neurotic persons had had sexual traumata in childhood, and then he found that they had had wishes. And then for several decades it was assumed in analytic writings that there was not such a thing as a real sexual trauma. Now we have to allow for this too.

In a deliberate examination of the external factor, I am thus far engaged in relating the analyst's personality, capacity for identifying with the patient, technical equipment, and so on, to the multifarious details of child-care, and then in a more specific way to the special state that a mother is in (perhaps father also, but he has less opportunity to show it) in the short time-space covering the later stages of pregnancy and the first months of the infant's life.

Psycho-analysis as we learn it is not at all like child-care. In fact, parents who interpret the unconscious to their children are in for a bad time. But in the part of our work as analysts that I am referring to there is nothing we do that is unrelated to

child-care or to infant-care. In this part of our work we can in fact learn what to do from being parents, from having been children, from watching mothers with very young babies or babies unborn, from correlating parental failures with subsequent clinical states of ill children. While we know that psycho-neurotic illness is not caused by parents, we also know that the mental health of the child cannot become established without good-enough parental or maternal care. We also know that a corrective environmental experience does not directly cure the patient any more than a bad environment directly causes the illness structure. I refer to this again at the end of this paper.

I now wish to refer back to my fragment of clinical material. Very early in the analysis this patient had become represented in her dream material by frail and often maimed creatures, and now she had dreamed of the tortoise with a soft shell.[1] You will have noted that this points the way to a regression to dependence that is bound to come. The patient had had several years of analysis along ordinary lines by an analyst who disallowed regression if this threatened to become acted out and to involve dependence on the analyst. She was therefore over-ripe for this part of the total analytic procedure, though of course needing as much as anyone else does the usual interpretations that become appropriate from day to day, or from minute to minute.

If I go a little further into the interpretative problem in the analysis of this fragment, I think I can show how interwoven are these two things: the intrapsychic mechanisms and dependence, which by definition involves the environment and its behaviour.

I had plenty of material in this case for the interpretation of the patient's reaction to my going away in terms of oral sadism belonging to love reinforced by anger—anger with me and all the others in her life who have gone away, including the mother who weaned her. I could have weighed in, fully justified in terms of what the patient had told me, but then I should have been a bad analyst making good interpretations. I should have been a bad analyst because of the way the material had been given me. All the time in our analytic work we are assessing and reassessing the ego-strength of the patient. The material had been given me in a way that indicated that the patient knew she could trust me not to use it brusquely. She is hypersensitive to all drugs and to all illnesses and to slight criticisms, and I must expect her to be sensitive to any mistake I make in my estimation of the strength of her ego. Something central in her personality only too easily

[1] By the way, she could also be a horse that had to be shot, else it would have kicked its way out of an aeroplane.

feels the threat of annihilation; clinically of course she becomes tough and extremely independent, well defended, and along with this goes a sense of futility and of being unreal.

In fact her ego is not able to accommodate any strong emotion. Hate, excitement, fear—each equally separates off, like a foreign body, and all too easily becomes localized in a bodily organ which goes into spasm and tends to destroy itself by a perversion of its physiological functioning.

The reason why the regressive and dependence dreams have appeared has to do chiefly with her finding that I do not use every bit of material for interpretation, but that I store everything up for use at the right moment and content myself for the present with making preparation for meeting the dependence that is coming up. This dependence phase will be very painful for the patient, and she knows it, and a risk of suicide goes with it, but, as she says, there is no other way. There *is* another way, for if her analyst is not able to meet her dependence so that the regression becomes a therapeutic experience, she will break down into psychosomatic illness, which produces the much-needed nursing but not the insight or the mental care that can really make a difference. The analyst needs to know why the patient would rather kill himself or herself than live under threat of annihilation.

By looking at this bit of material in this way, we reach a point where we are discussing both analysis and the meeting of dependence needs. A string of 'good' interpretations relative to the general content of the session would produce anger or excitement, and it is not yet possible for this patient to deal with these all-out emotional experiences. It would therefore be bad in the sense of my present statement of analytic procedure to interpret the very things that are relative to the premature separation.

In the course of a talk in which we made plans for the future and discussed the nature of her illness and the risks that are inherent in going on with the treatment, I said:[1] 'So here is yourself ill, and we can see that the physical illness hides an extreme reaction to my going away, although you are not able to reach to a direct feeling-awareness of this. So that you could say that I have caused your illness, just as others have caused you to be ill when you were a baby, and you could be angry.' She said: 'But I'm not.' (Actually she holds me in an idealized position at present, and tends to find doctors of the body to be persecutors.) So I said: 'The path is there, wide open for your hatred and anger, but anger refuses to walk down the path.'

[1] I was clearly affected by the intellectual level of her method of presenting material.

The patient told me that the main thing that brought about the very swift, involuntary development towards dependence was the fact that I let things be, and wanted to see what each hour would bring. Actually the pattern had been that she would start almost as if the hour were a social visit. She would lie down and display very clear intellectual awareness of herself and of her surroundings. I played in with all this, and there was much silence. Near the end of each hour she would quite unexpectedly remember a dream, and she would then get my interpretation. The dreams presented in this way were not very obscure, and the dream resistance could usually be seen to reside in the forty-five minutes of material that preceded it and that was not good material for interpretation. That which has been dreamed and remembered and presented is within the capacity of the ego-strength and structure.

So this patient will be very dependent on me over a phase; the hope is that for her sake, as well as for mine, this dependence will be kept within the confines of the transference and of the analytic setting and sessions. But how can one tell in advance? How can one make this sort of diagnosis that is concerned with assessment of needs?

In terms of *child-care*, I would like to exemplify regression in the service of the ego by looking at the phases of spoiling which parents find one child needs from time to time—parents, that is, who do not spoil their child because of their own anxieties. Such phases of spoiling bring many a child through without any involvement of a doctor or a child guidance clinic. It is difficult to give a case without making it sound rare, and these are matters of common experience in family life, when parents care for their own children. For a few hours, or days, or weeks, in a special context, a child is treated as if of a younger age than is in fact true chronologically. Sometimes it happens when a child bangs his head or cuts his finger; he goes in a moment from four to two, and is screaming and consoling himself with his head in his mother's lap. Then in no time, or after a sleep, he is again very grown up, and more so than his own age warrants.

Here is a boy of two (Winnicott, 1963). He reacted very badly at twenty months to the mother's anxiety which she experienced when she conceived. It is part of her pattern to become extremely anxious at conception. He stopped using the pot and stopped using words, and his forward progress was held up. When the baby was born he was not hostile to the baby, but he wanted to be bathed like the baby. At breast-feeding time he started thumb-sucking, which had not previously been a feature. He made

special claims on the parents' indulgence, needing to sleep in their bed for many months. His speaking was delayed.

The parents met all these changes and demands in a satisfactory way, but the neighbours said that they were spoiling the boy. Eventually the boy emerged from his regression or withdrawal and the parents were able to finish with spoiling him when he was eight years old, after he had had a phase in which he was stealing money from them.[1]

This is a common type of case in child psychiatry, as I know it, especially in private practice when children are brought for symptoms that in child guidance might be considered to be insignificant. It has been an important part of my child psychiatry orientation to recognize that in such a case one does not immediately think of psycho-analysis; one thinks of supporting these parents in their management of their child's babyishness. One may be in a position, of course, to give psycho-analytic help, while the parents are carrying out the mental nursing of the patient, but it is a formidable matter to treat such a case by psycho-analysis if there is not a parental provision that will meet the mental nursing needs. Without the parents' mental nursing the psycho-analyst doing psycho-analysis must find the patient not only dreaming of being taken over by the analyst and into his or her home, but also actually needing to be taken in.

A corollary of this is that when an orthodox psycho-analysis of a child is successful there is an acknowledgement to be made by the psycho-analyst that the parents' home, relations, helpers, friends, etc., did nearly half the treatment. We do not have to make these acknowledgements out loud, but we need to be honest about these matters of the patient's dependence when we are theory-building.

Now I come to the earlier *infant-mother relationship*. A great deal has been written about this. I want to draw your attention to the part the mother plays at the time of her baby's very great dependence at the beginning. Although I believe readers are fully aware of these matters, I wish to go over the argument again so that it can be discussed.

Here I wish to refer to a paper by Zetzel (1956). I need not gather together all the threads that went to the making of this very valuable review of Current Concepts of Transference. I only want to take out of her paper the paragraphs in which she refers to my own work. She writes: 'Other analysts—Dr Winnicott, for example—attribute psychosis mainly to severe traumatic

[1] Miss Freud has taken up the subject of ego-regression in a paper published in the Menninger Bulletin (1963).

experiences, particularly of deprivation in early infancy. According to this point of view, profound regression offers an opportunity to fulfil, in the transference situation, primitive needs which had not been met at the appropriate level of development. Similar suggestions have been proposed by Margolin and others . . .'

It is valuable to me to have the opportunity to take up this description of my attitude to this subject, a subject that has great importance because of the fact that one of the growing points of psycho-analysis is in the treatment of the borderline case and in the attempt to formulate a theory of psychotic illness, especially schizophrenia.

Firstly, do I attribute psychosis mainly to severe traumatic experiences, partly of deprivation in early infancy? I can well understand that this is the impression that I have given, and I have changed the way I present my view in the course of the past decade. It is necessary, however, to make some corrections. I have definitely stated that in the aetiology of psychotic illness and particularly of schizophrenia (except in so far as hereditary elements are operative) there has to be noted a failure in the total infant-care process. In one paper I went so far as to state: 'Psychosis is an environmental deficiency disease.' Zetzel uses the term 'severe traumatic experiences', and these words imply bad things happening, things that look bad from the observer's point of view. The deficiencies that I am referring to are failures of basic provision—like my going away to the U.S.A. when my patient is not ready for the reactions that occur in her to my going. In other papers I have explored in great detail the kinds of failure that constitute failure of basic provision. The main point is that these failures are unpredictable; they cannot be accounted for by the infant in terms of projection, because the infant has not yet reached the stage of ego-structuring that makes this possible, and they result in the *annihilation* of the individual whose going-on-being is interrupted.

Mothers who are not themselves ill do in fact avoid this type of failure of care of an infant.

Under the heading 'Primary Maternal Preoccupation' I have referred to the immense changes that occur in women who are having a baby, and it is my opinion that this phenomenon, whatever name it deserves, is essential for the well-being of the infant. It is essential because without it there is no one who is sufficiently identified with the infant to know what the infant needs, so that the basic ration of adaptation is missing. It will be understood that I am not just referring to adaptation in terms of the satisfying of id-drives.

A basic ration of environmental provision facilitates the very important *maturational developments* of the earliest weeks and months, and any failure of early adaptation is a traumatic factor interfering with the integrative processes that lead to the establishment in the individual of a self that goes on being, that achieves a psychosomatic existence, and that develops a capacity for relating to objects.

So a statement of my view would include the following:

(i) It is in psycho-neurotic illness that we find the conflicts that are truly personal to the individual, and relatively free from environmental determinants. One needs to be healthy enough at the toddler age to achieve psycho-neurotic illness, let alone health in this area.

(ii) It is in the earlier stages that the basis of the mental health of the individual is being laid down. This involves:
   (*a*) maturational processes, which are inherited tendencies, and
   (*b*) the environmental conditions that are needed if the maturational processes are to become actual.
   In this way, failure of early basic environmental provision disturbs maturational processes, or prevents their contributing to the individual child's emotional growth, and it is this failure of the maturational processes, integration, etc., that constitutes the ill-health that we call psychotic. This failure of the environmental provision (privation) is not usually referred to by the word 'deprivation', hence my need to correct the words of Zetzel's reference to my work.

(iii) A complication in the making of this statement is the fact that there is an intermediate position, one in which environmental provision is at first good, and then fails. It succeeds in that it allows of ego-organization of considerable degree, and then it fails at a stage before the individual has become able to establish an internal environment—that is, to become independent. This is what is usually called a 'deprivation', and it does not lead to psychosis; it leads to a development in the individual of an 'antisocial tendency', which may in turn force the child into having a character disorder and becoming a delinquent and a recidivist.

All these over-simplifications need elaboration which I have given them elsewhere but which I cannot gather together here. I wish, however, to refer briefly to a few of the effects of this attitude to mental disorder on our way of thinking.

(i) One is that it is in the psychoses—not in the psycho-neuroses —that we must expect to find examples of self-cure. Some environmental happening, perhaps a friendship, may provide a correction of a failure of basic provision, and may unhitch the catch that prevented maturation in some respect or other. In any case, it is sometimes the very ill child in child psychiatry who can be enabled to start growing by snack-bar psychotherapy, whereas in the treatment of psycho-neurosis one always wants to be able to provide a psycho-analytic treatment.

(ii) The second is that a corrective experience is not enough. Certainly no analyst *sets out to provide* a corrective experience in the transference, because this is a contradiction in terms; the transference in all its details comes through the patient's unconscious psycho-analytic process, and depends for its development on the interpreting that is always relative to material presented to the analyst.

Of course, the practising of a good psycho-analytic technique *may* in itself be a corrective experience, and for instance in analysis a patient may for the first time get full attention from another person, limited though it be to the reliably established fifty-minute session; or may for the first time be in contact with someone who is capable of being objective. And so on.

But even so, the corrective provision is never enough. What is it that may be enough for some of our patients to get well? In the end the patient uses the analyst's failures, often quite small ones, perhaps manœuvred by the patient, or the patient produces delusional transference elements (Little, 1958) and we have to put up with being in a limited context misunderstood. The operative factor is that the patient now hates the analyst for the failure that originally came as an environmental factor, outside the infant's area of omnipotent control, but that is *now* staged in the transference.

So in the end we succeed by failing—failing the patient's way. This is a long distance from the simple theory of cure by corrective experience. In this way, regression can be in the service of the ego if it is met by the analyst, and turned into a new dependence in which the patient brings the bad external factor into the area of his or her omnipotent control, and the area managed by projection and introjection mechanisms.

Finally, in regard to the patient to whom I have referred, I must not fail in the child-care and infant-care aspects of the treatment until at a later stage when *she will make me fail* in ways

determined by her past history. What I fear is that by giving myself the experience of a month abroad I may have already failed prematurely and have joined up with the unpredictable variables of her infancy and childhood, so I may have truly made her ill now, as indeed the unpredictable external factors did make her ill in her infancy.

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M. M. R. K.

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