Treatment

Briefly, the treatment of the antisocial tendency is not psychoanalysis. It is the provision of child care which can be rediscovered by the child, and into which the child can experiment again with the id impulses, and which can be tested. It is the stability of the new environmental provision which gives the therapeutics. Id impulses must be experienced, if they are to make sense, in a framework of ego relatedness, and when the patient is a deprived child ego relatedness must derive support from the therapist's side of the relationship. According to the theory put forward in this paper it is the environment that must give new opportunity for ego relatedness since the child has perceived that it was an environmental failure in ego support that originally led to the antisocial tendency.

OK. So, in summary, Winnicott says that the treatment of the antisocial tendency is definitively not psychoanalysis. It is affirmatively the provision of child care. This child care must allow the child to experiment again with id impulses. It must be testably stable and reliable. If the venue in which this is to take place is the therapeutic relationship, then that relationship must be stable, and it must be ego-related, because the adult environment must give to the child what was missing in his early history.

If the child is in analysis, the analyst must either allow the weight of the transference to develop outside the analysis, or else must expect the antisocial tendency to develop full strength in the analytic situation, and must be prepared to bear the brunt.

If the child is in therapy, the therapist must expect the antisocial tendency to emerge in the therapy, and must be prepared to bear the brunt of it.

6 Primary maternal preoccupation

(1956)

Winnicott, D. W. (1956). Primary maternal preoccupation. In *Through paediatrics to psycho-analysis: Collected papers* (pp. 300–305). Levittown, PA: Brunner Mazel, 1992.

In this paper, Winnicott introduces us to the special psychological state that a pregnant mother enters prenatally, and sustains approximately for the first month postnatally. He studies this as both a pediatrician and psychoanalyst, and blends these two vantage points in this paper. Winnicott observes that it takes this state of "primary maternal preoccupation" to allow a mother to feel her way into the infant's place and so to meet his/her needs. As those needs are met and an infant is allowed to be in his/her "going-on-being" place, the infant begins to stretch beyond bodily experiences, and to "imaginatively elaborate" those experiences, ever-so-gradually beginning to become a more integrated "I." He is straightforward about what happens to those who do not experience this good-enough environment. They do not feel real to themselves. They instead feel a deep sense of futility. Throughout the paper, he uses the words "mother" and "maternal," for which we might legitimately substitute the gender-neutral term, "primary caregiver."

He begins:

This contribution is stimulated by the discussion published in the *Psychoanalytic Study of the Child*, Volume IX, under the heading: "Problems of Infantile Neurosis". The various contributions from Miss Freud in this discussion add up to an important statement of present-day psycho-analytic theory as it relates to the very early stages of infantile life, and of the establishment of personality.

Winnicott writes in the context of the intellectual environment created by Freud and which he currently co-occupies with Anna Freud and Melanie Klein, both child therapists and major contributors to psychoanalytic understandings of child development. He will also draw on the work of Heinz Hartmann in this paper.

> I wish to develop the theme of the very early infant–mother relationship, a theme that is of maximal importance at the beginning, and that only gradually takes second place to that of the infant as an independent being.
>
> It is necessary for me first to support what Miss Freud says under the heading "Current Misconceptions". "Disappointments and frustrations are inseparable from the mother–child relationship ... To put the blame for the infantile neurosis on the mother's shortcomings in the oral phase is no more than a facile and misleading generalization. Analysis has to probe further and deeper in its search for the causation of neurosis." In these words Miss Freud expresses a view held by psycho-analysts generally.

So Winnicott begins by naming Anna Freud's position, which is to attempt to limit the blaming of the development of infantile neurosis on the early maternal environment. Infantile neurosis refers to chronic distress in the developing child in the form of symptoms such as depression, anxiety, obsessive behaviors, and so on, during what Freud would refer to as the oral phase.

He continues:

> In spite of this we may gain much by taking the mother's position into account. There is such a thing as an environment that is not good enough, and which distorts infant development, just as there can be a good enough environment, one that enables the infant to reach, at each stage, the appropriate innate satisfactions and anxieties and conflicts.

Heinz Hartmann (1939) had coined the term "average expectable environment" to denote the prevalent view that infants are broadly equipped to adapt to the demands of the environment into which they are born. Hartmann felt that infants are inherently able to fit into a range of physical and psychological environments, and that they could flourish in any environment that was responsive enough to the child's psychological needs (Palombo et al., 2010). Winnicott takes issue with this view in this paper, arguing that there are certain *essentials* that must be there in the very beginning in order for development to proceed normally.

> Miss Freud has reminded us that we may think of pregenital patterning in terms of two people joined to achieve what for brevity's sake one might call "homeostatic equilibrium" (Mahler, 1954). The same thing is referred to under the term "symbiotic relationship". It is often stated that the mother of an infant becomes biologically conditioned for her job of special orientation to the needs of her child. In more ordinary language there is found to be an identification—conscious but also deeply unconscious—which the mother makes with her infant.

OK. Winnicott is positioning his case in the context of what were the current thought currents about mothers and infants. The language of the day suggested that there was a certain automaticity pre-programmed by biology that in some way almost guaranteed an "average expectable environment."

> I think that these various concepts need joining together and the study of the mother needs to be rescued from the purely biological. The term symbiosis takes us no further than to compare the relationship of the mother and the infant with other examples in animal and plant life—physical interdependence. The words homeostatic equilibrium again avoid some of the fine points which appear before our eyes if we look at this relationship with the care it deserves.
>
> We are concerned with the very great psychological differences between, on the one hand, the mother's identification with the infant and, on the other, the infant's dependence on the mother; the latter does not involve identification, identification being a complex state of affairs inapplicable to the early stages of infancy.

OK. So the symbiotic relationship that Anna Freud is addressing requires something more from the mother than mere biology leading to homeostatic equilibrium. According to Winnicott, it requires *identification* with the infant on the part of the mother. He is also clear that the relationship is a psychologically uneven one—that it is not accurately described by the concept of interdependence because it is the infant, not the mother, who is wholly dependent.

> Miss Freud shows that we have gone far beyond that awkward stage in psycho-analytic theory in which we spoke as if life started for the infant with the oral instinctual experience. We are now engaged in the study of early development and of the early self which, if development has gone far enough, can be strengthened instead of disrupted by id experiences.

The ego had been seen by Sigmund Freud as drawing its energy from the instinctual experiences of the id, which Freud believed existed from the very start. He felt that id experiences of frustration and conflict caused the ego to have to grow and develop in order to counter the impulses of the id. Here Winnicott is asserting that instinctual experience—id experience—can be a

strengthening instead of a disrupting influence—can be a positive force in the development of the early self.

> Miss Freud says, developing the theme of Freud's term "anaclitic": "the relationship to the mother, although the first to another human being, is not the infant's first relationship to the environment. What precedes it is an earlier phase in which not the object world but the body needs and their satisfaction or frustration play the decisive part."

Let's first define "anaclitic": an adjective describing relationships that are characterized by the strong dependence of one person on another. Winnicott agrees with Anna Freud that there is an early phase of development wherein the infant's bodily needs are the main issue.

> Incidentally I feel that the introduction of the word "need" instead of "desire" has been very important in our theorizing, but I wish Miss Freud had not used the words "satisfaction" and "frustration" here; a need is either met or not met, and the effect is not the same as that of satisfaction and frustration of id impulse.

OK. So Winnicott is re-drawing the playing field. Needs are either met or not met, period. He's suggesting that "satisfaction" and "frustration" are not relevant to the earliest phases of infancy. He does not say this, but it's a ready inference to be made at this point. Needs that are unmet at the earliest phase cause some kind of developmental distortion in the infant, rather than mere momentary frustration.

He continues:

> I can bring Greenacre's reference (1954) to what she names the "lulling" type of rhythmic pleasures. Here we find an example of need that is met or not met, but it would be a distortion to say that the infant who is not lulled reacts as to a frustration. Certainly there is not anger so much as some kind of distortion of development at an early phase.

He's suggesting here that the early phase of infancy cannot be described with full-bodied emotional words like frustration, anger, or satisfaction. It's more simple than that. Ministrations are there or not there. Needs are met or not met. And if not met, some kind of distortion of development takes place. He'll elaborate what he means by distortion of development as he proceeds.

He gathers it up:

> Be that as it may, a further study of the function of the mother at the earliest phase seems to me to be overdue, and I wish to gather together the various hints and put forward a proposition for discussion.

> **Maternal preoccupation**
>
> It is my thesis that in the earliest phase we are dealing with a very special state of the mother, a psychological condition which deserves a name, such as *Primary Maternal Preoccupation*. I suggest that sufficient tribute has not yet been paid in our literature, or perhaps *anywhere*, to a very special psychiatric condition of the mother, of which I would say the following things:
>
> It gradually develops and becomes a state of heightened sensitivity during, and especially towards the end of, the pregnancy.
> It lasts for a few weeks after the birth of the child.
> It is not easily remembered by mothers once they have recovered from it.
> I would go further and say that the memory mothers have of this state tends to become repressed.

OK. He's given a name and characteristics to this state of heightened maternal sensitivity toward the end of pregnancy and in the beginning weeks of the life of the infant: primary maternal preoccupation. He continues:

> This organized state (that would be an illness were it not for the fact of the pregnancy) could be compared with a withdrawn state, or a dissociated state, or a fugue, or even with a disturbance at a deeper level such as a schizoid episode in which some aspect of the personality takes over temporarily. I would like to find a good name for this condition and to put it forward as something to be taken into account in all references to the earliest phase of infant life. I do not believe that it is possible to understand the functioning of the mother at the very beginning of the infant's life without seeing that she must be able to reach this state of heightened sensitivity, almost an illness, and to recover from it. (I bring in the word "illness" because a woman must be healthy in order both to develop this state and to recover from it as the infant releases her. If the infant should die, the mother's state suddenly shows up as illness. The mother takes this risk.)

He describes this state of heightened maternal sensitivity to her infant as akin to a psychological illness, except that she recovers from it in response to the infant's "releasing" her. Although he is comparing it to an illness, it is not an illness. He believes that this state is crucial to the infant's "undistorted" development.

> I have implied this in the term "devoted" in the words "ordinary devoted mother" (Winnicott, 1949). There are certainly many women who are good mothers in every other way and who are capable of a rich and fruitful life but who are not able to achieve this "normal illness" which enables them to adapt delicately and sensitively to the infant's needs at the very beginning; or they achieve it with one child but not with another. Such women are not able to become preoccupied with their own infant to the exclusion of other interests, in the way that is normal and temporary. It may be supposed that there is a "flight to sanity" in some of these people. Some of them certainly have very big alternative concerns which they do not readily abandon or they may not be able to allow this abandonment until they have had their first babies. When a woman has a strong male identification she finds this part of her mothering function most difficult to achieve, and repressed penis envy leaves but little room for primary maternal preoccupation.

OK, so now Winnicott is defining more specifically what primary maternal preoccupation is: the capacity "to adapt delicately and sensitively to the infant's needs," and "to become preoccupied with their own infant to the exclusion of other interests." He is also saying that not everyone achieves this state, and he enumerates some of the causes that prevent some mothers from achieving this state. (We might think in different terms today about Winnicott's reference to women who have a "strong male identification." He was writing in 1956, and was still influenced by Freud's concept of penis envy. It was, however, part of Winnicott's thinking that the primary issue was attunement to the baby, whether it came from the birth mother, the adoptive mother, the father, the grandparent, etc.). So, he uses the words "mother" and "maternal," for which we might legitimately substitute "primary caregiver."

> In practice the result is that such women, having produced a child, but having missed the boat at the earliest stage, are faced with the task of making up for what has been missed. They have a long period in which they must closely adapt to their growing child's needs, and it is not certain that they can succeed in mending the early distortion. Instead of taking for granted the good effect of an early and temporary preoccupation they are caught up in the child's need for therapy, that is to say, for a prolonged period of adaptation to need, or spoiling. They do therapy instead of being parents.

Here Winnicott hints at the consequences that occur when a mother cannot achieve this primary maternal preoccupation: there is "early distortion" and the subsequent need of the child for a prolonged period of adaptation to need. He quips that mothers who have not been able to achieve this state in the first few weeks of an infant's life have to "pay for it" by becoming like the child's "therapist"—meaning, adapting carefully to his every need—for a very long time, instead of simply being his/her parent.

> The same phenomenon is referred to by Kanner (1943), Loretta Bender (1947) and others who have attempted to describe the type of mother who is liable to produce an "autistic child" (Creak, 1951; Mahler, 1954).

Modern research on autism has ruled out parent care as a cause of autism. Research suggests that autism develops from a combination of genetic and non-genetic, or environmental, influences, but researchers have not yet identified causal factors.

Winnicott continues:

> It is possible to make a comparison here between the mother's task in making up for her past incapacity and that of society attempting (sometimes successfully) to bring round a deprived child from an antisocial state towards a social identification. This work of the mother (or of society) proves a great strain because it does not come naturally. The task in hand properly belongs to an earlier date, in this case to the time when the infant was only beginning to exist as an individual.
>
> If this thesis of the normal mother's special state and her recovery from it be acceptable, then we can examine more closely the infant's corresponding state.

Again, Winnicott speaks to consequences that can occur when the initial primary maternal preoccupation is not achieved. Sometimes society has to deal with this lack of sensitive care in the first weeks of life (and perhaps beyond). He speaks of the task of bringing round a "deprived" child from an antisocial or delinquent or acting-out state toward a more pro-social identification. He is straightforward in his language: "The task in hand properly belongs to an earlier date"—to the time when the infant "was only beginning to exist as an

individual." Otherwise, it may take much effort to back-fill what should have happened at the very beginning life stage.

He moves on to a description of the postnatal infant:

> The infant has
> A constitution.
> Innate developmental tendencies ("conflict-free area in ego").
> Motility and sensitivity.
> Instincts, themselves involved in the developmental tendency, with changing zone-dominance.

OK. Here he has a list of the starting point for an infant. The first item on his list of what an infant has to begin with is easy to understand. An infant starts with a constitution.

Next on the list is "innate developmental tendencies ('conflict-free area in ego')." This one requires some explanation. "Innate developmental tendencies" include most prominently in Winnicott's thinking the overall tendency toward integration. But here he is less specific. He just says there are developmental tendencies—the tendency to develop over time. But he then qualifies this with: ("conflict-free area in ego"). What does this refer to? Here Winnicott is drawing both on Freud's structural model (id, ego, superego) and Hartmann's revision of Freud's model. Hartmann, the putative father of Ego Psychology, believed, in contrast to Freud, that the ego did not develop *from* the id, but that the id and the ego develop simultaneously from the beginning, and that they function independently, yet in synchrony. Hartmann (1964) also argued that the ego is not limited to its role in conflict resolution (i.e., warding off id impulses and avoiding the guilt and self-punishment meted out by the superego). He thought instead that the healthy ego included an entire sphere of ego functions that were independent of mental conflict. Examples of ego-operations within this conflict-free sphere were capacities like intelligence, cognition, memory, planning, and so on. He felt that the ego could operate to find non-conflictual ways to gratify impulses, and that this was made possible by the opportunities afforded by the person's social/relational context.

OK. So we now know that Winnicott felt that there was an incipient ego from the very start. Not yet developed, but there to develop.

Next on the list is "motility"—an infant moves arms, legs, head, trunk—has muscles that move around. S/he also has "sensitivity"—can feel touch and pressure and pain and warmth and coldness and gravity, and has sensitivities across the other senses of hearing and sight and smell and taste.

Last on his list is "instincts." He reminds us that instincts themselves have a developmental tendency, with changing zone-dominance. All right, so, instincts originate from the somatic organization. They are the source of our bodily needs, wants, desires, and impulses. He does not use the word "id," which has more complex associations, but includes changing zone-dominance, which is

an allusion to Freud's psychosexual stages of development: oral, followed by anal, and then by genital and finally by phallic.

OK. So now he moves a bit further:

> The mother who develops this state that I have called "primary maternal preoccupation" provides a setting for the infant's constitution to begin to make itself evident, for the developmental tendencies to start to unfold, and for the infant to experience spontaneous movement and become the owner of the sensations that are appropriate to this early phase of life. The instinctual life need not be referred to here because what I am discussing begins before the establishment of instinct patterns.

In this paragraph he loops backward to the elements of an infant that he has just listed. He says that this state of special sensitivity on the part of the mother "provides a setting" in which three things occur:

1. The infant's constitution begins to make itself evident.
2. The infant's "developmental tendencies" begin to unfold.
3. The infant can begin to experience spontaneous movement (motility) and to "become the owner of" his sensations and sensitivities. He is not right away the owner of his sensations and sensitivities. This takes the provision of this special setting of primary maternal preoccupation.

He leaves instincts off the list because instinct patterns are established later in development—not in these first few weeks.

> I have tried to describe this in my own language, saying that if the mother provides a good enough adaptation to need, the infant's own line of life is disturbed very little by reactions to impingement. (Naturally, it is the reactions to impingement that count, not the impingements themselves.) Maternal failures produce phases of reaction to impingement and these reactions interrupt the "going on being" of the infant. An excess of this reacting produces not frustration but a threat of annihilation. This in my view is a very real primitive anxiety, long antedating any anxiety that includes the word death in its description.

OK. Winnicott is introducing us here to some important Winnicottian concepts and language. First, the "going on being" of the infant. Winnicott will use this evocative phrase in other papers. It means exactly what it says—the uninterrupted being of a little one. This is the state the little newborn needs in order to progress seamlessly to further developmental steps. Second, he introduces "reactions to impingements." Another [illegible]ing

on being of the baby is an impingement to him/her. If a caregiver's care is good enough, there will be very few impingements, but if there is an excess of these impingements, then it causes a *dire* state in the infant. This state is not frustration, which would be beyond the newborn's capacity to feel as frustration. It is instead, in Winnicott's words, the *threat of annihilation*—the threat to cease to exist, to disappear. This is one of the most—if not the most—dreadful anxieties we can experience as humans. It's more profound even than the feeling that one may be imminently facing death; it is the threat of being reduced to nothing, apprehended at a time before one's thinking apparatus has words with which to think about it. It is a state of *sheer terror* that *disrupts the developmental process of the infant.* Winnicott will call this in other works an "unthinkable anxiety."

He continues:

> In other words, the basis for ego establishment is the sufficiency of "going on being", uncut by reactions to impingement. A sufficiency of "going on being" is only possible at the beginning if the mother is in this state that (I suggest) is a very real thing when the healthy mother is near the end of her pregnancy, and over a period of a few weeks following the baby's birth.

"Ego establishment" means the gradually developing sense of being a self, of having an I. This is accomplished over time—not right away—via the sufficiency of "going on being" with few enough reactions to impingement.

> Only if a mother is sensitized in the way I am describing can she feel herself into her infant's place, and so meet the infant's needs. These are at first body-needs, and they gradually becomes ego-needs as a psychology emerges out of the imaginative elaboration of physical experience.

It takes this state of primary maternal preoccupation to allow a mother to feel her way into the infant's place and so to meet his/her needs. Winnicott has already written about this first set of body-needs in his paper "Mind and its relation to the psyche-soma" (1949). As those needs are met and an infant is allowed to be in his/her "going-on-being" place, the infant begins to stretch beyond bodily experiences, and to "imaginatively elaborate" those experiences, ever-so-gradually beginning to become an "I" with, to quote Winnicott, "ego-needs." Thus, a baby's fantasy capacity begins as a developmental achievement.

I'll take the next section thought by thought.

> There comes into existence an ego-relatedness between mother and baby, from which the mother recovers, and out of which the infant may eventually build the idea of a person in the mother.

There is quite a progression that has to take place in the infant before s/he can apprehend that there is a *source* of the things that are happening to him/her, and that the source is a person—the mother. Bodily experiences have to build to the capacity to "imaginatively elaborate" those experiences, which will become the ground for the baby's psyche. Ego-relatedness comes after the psyche begins to stretch into itself in the context of thousands of repetitions of bodily based experiences. It will be weeks to months before there is "ego-relatedness," meaning person-to-person relatedness from the infant's side of things. The infant may eventually build the idea of a person in the mother, but this takes time and development. The mother "recovers" from her primary maternal preoccupation, but from the beginning she can recognize the otherness of the infant. The infant cannot do this from the start.

He continues:

> From this angle the recognition of the mother as a person comes in a positive way, normally, and not out of the experience of the mother as the symbol of frustration.

When a mother is able to achieve this state of primary maternal preoccupation, the infant is able to come to the graceful and gradual recognition of the mother as a person in contrast to what happens when the mother cannot feel her way into the infant's needs, and so is a source of impingement leading to experiences of annihilation in the infant, and thus (gradually) becomes a symbol of frustration.

> The mother's failure to adapt in the earliest phase does not produce anything but an annihilation of the infant's self.

As he has said above, impingements via the mother's failure to adapt in the earliest phase of infancy create the terror of total annihilation in the infant. This is in part because the infant has not yet developed the capacity to feel more sophisticated feelings such as frustration. Needs are either met or not met, leading either to going-on-being or to disruptions in going-on-being (impingements), which can accumulate to unspeakable anxieties, namely, the terror of annihilation of the self—the reduction of the self to nothingness.

> What the mother does well is not in any way apprehended by the infant at this stage. This is a fact according to my thesis. Her failures are not felt as maternal failures, but they act as threats to personal self-existence.

Here Winnicott is letting us in on the psychological state of the very first weeks of an infant's life. His observation of the psychic life of infants has led him to posit this as "fact": that an infant is not comprehending the quality of his experience or the source of that experience. The infant does not think, "Ah, this is going well." S/he experiences either going-on-being or impingements to going-on-being which can escalate into unbearable threats to personal self-existence.

> In the language of these considerations, the early building up of the ego is therefore silent. The first ego organization comes from the experience of threats of annihilation and from which, repeatedly, there is recovery. Out of such experiences confidence in recovery begins to be something which leads to an ego and to an ego capacity for coping with frustration.

OK. So Winnicott is now using new phrasing: "the first ego organization." The infant at first has only the *potential* for ego organization. Organization of the ego awaits the passing of time, the accruing of experience, and further maturing in order to come into being. He introduces a new thought here: that there are threats of annihilation that can be recovered from. Not at first, but as time passes, impingements that are well timed to the infant's maturing process can actually be growth-producing. Maternal miscues and mis-timings that are not too overwhelming, plus recovery from them (mediated by the attuned mother) can actually precipitate the beginning of the formation of an ego—an evolving sense of I—in the infant. As such experiences—threats of annihilation followed by recovery—occur and recur, the infant begins to build confidence in the process of recovery, which stimulates the growth of the ego, which in turn gradually develops the capacity to identify and cope with frustration.

> It will, I hope, be felt that this thesis contributes to the subject of the infant's recognition of the mother as a frustrating mother. This is true later on but not at this very early stage. At the beginning the failing mother is not apprehended as such. Indeed a recognition of absolute dependence on the mother and of her capacity for primary maternal preoccupation, or whatever it is called, is something which belongs to extreme sophistication, and to a stage not always reached by adults. The general failure of recognition of absolute dependence at the start contributes to the fear of *woman* that is the lot of both men and women (Winnicott, 1950, 1957a).

Winnicott here partially restates himself. He is driving home the point that at the earliest stage of absolute dependence the infant does not apprehend that impingements are coming from a failing or frustrating mother. Such a recognition of one's absolute dependence at the beginning of life comes at a much later stage, which Winnicott says actually isn't even reached by some adults. (He will clarify this statement in other papers.) He then offers, parenthetically, that the failure to recognize how absolutely dependent we are in the very beginning of our lives leads to a fear of the life-and-death power of woman, in both men and women. (This may, in fact, be the psychological ground for all expressions of misogyny.)

> We can now say why we think the baby's mother is the most suitable person for the care of that baby; it is she who can reach this special state of primary maternal preoccupation without being ill. But an adoptive mother, or any woman who can be ill in the sense of "primary maternal preoccupation", may be in a position to adapt well enough, on account of having some capacity for identification with the baby.

OK. Here Winnicott asserts some good news: that the baby's biological mother is usually the most suitable person for the care of the baby because she is likely to be able to reach this state of primary maternal preoccupation, but that an adoptive mother can achieve this primary maternal preoccupation also.

> According to this thesis a good enough environmental provision in the earliest phase enables the infant to begin to exist, to have experience, to build a personal ego, to ride instincts, and to meet with all the difficulties inherent in life. All this feels real to the infant who becomes able to have a self that can eventually even afford to sacrifice spontaneity, even to die.

OK. This is a mouthful from Winnicott! He is now shifting his language from maternal care to "environmental provision." With good-enough care/provision for the infant, there is a developmental progression. The infant: (1) begins to exist, and then (2) has experiences, and then (3) (big jump) builds a personal ego, and then is able to (4) "ride instincts," and finally (5) progresses to meet with all the difficulties inherent in life.

Winnicott has touched on the first three on this list, but made only brief mention of instincts in the beginning of his paper. Remember that instincts originate from somatic organization. They are the source of our bodily needs, wants, desires, and impulses, and have shifting zone-dominance over time. An infant at first cannot even apprehend that he has his own needs, wants, desires, and impulses. The awareness of instincts and satisfaction of them requires the slow building up of a personal ego—a self. He ends his paragraph with a

complex assertion: that if all these steps that culminate in being able to recognize and seek to satisfy instincts go well enough, "all of this feels real to the infant." He implies the opposite, though, that if these steps do not go well enough, the emerging person will not feel *real*. He will take up this idea of real versus not real in other papers.

Finally, he asserts that those who successfully develop such a self can afford to not "ride" instincts—to sacrifice spontaneity—and even to be real to their own death, a wish that Winnicott is reported to have had concerning himself, "May I be alive when I die" (2016).

He continues:

> On the other hand, without the initial good-enough environmental provision, this self that can afford to die never develops. The feeling of real is absent and if there is not too much chaos the ultimate feeling is of futility. The inherent difficulties of life cannot be reached, let alone the satisfactions. If there is not chaos, there appears a false self that hides the true self, that complies with demands, that reacts to stimuli, that rids itself of instinctual experiences by having them, but that is only playing for time.

So now he is straightforward about what happens to those who do not experience this good-enough environment. They do not feel real to themselves. They feel a sense of futility. They can neither experience the satisfactions of life, nor really show up for the difficulties. They live their lives through the medium of a false self as opposed to a true self. Their false self is compliant with the demands that come from outside itself, and is reactive to stimuli. The false self "rids itself of instinctual experience," meaning that it is not really present to its own bodily needs, wants, desires, and impulses. It enacts them but is not truly present for them. If there is too much chaos, then all there is is the chaos.

> It will be seen that, by this thesis, constitutional factors are more likely to show up in the normal, where the environment in the first phase has been adaptive. By contrast, when there has been failure at this first phase, the infant is caught up in primitive defence mechanisms (false self, etc.)which belong to the threat of annihilation, and constitutional elements tend to become overridden (unless physically manifest).

OK, remember that "constitutional factors" refer to everything that is inherited, genetically encoded, and present at birth. These are more likely to be expressed when the first phase of absolute dependence has been adaptive. When there have been compromises during this phase, constitutional factors do not tend to get expressed unless they are physically manifest, such as hair color, and

so on. They tend to be overridden by the emerging child's need to cope with threats of annihilation and the consequent defenses—like the development of the false self.

> It is necessary here to leave undeveloped the theme of the infant's introjection of illness patterns of the mother, though this subject is of great importance in consideration of the environmental factor in the next stages, after the first stage of absolute dependence.

OK. He hints at the next phase of development wherein a child can take in the emotional illness patterns of the mother.

> In reconstructing the early development of an infant there is no point at all in talking of instincts, except on a basis of ego development.
>
> There is a watershed:
>
> Ego maturity—instinctual experiences strengthen ego.
>
> Ego immaturity—instinctual experiences disrupt ego.
>
> Ego here implies a summation of experience. The individual self starts a summation of resting experience, spontaneous motility, and sensation, return from activity to rest, and the gradual establishment of a capacity to wait for recovery from annihilations; annihilations that result from reactions to environmental impingement. For this reason the individual needs to start in the specialized environment to which I have here referred under the heading: Primary Maternal Preoccupation.

The very early infant does not experience instincts—bodily needs, wants, desires, and impulses—until he has developed enough ego—enough self—to inhabit his own instincts. Then, he can indeed experience his resting self, his spontaneous motility, his sensation, his return to rest. The gradual build-up of confidence in recovery from impingements (timed to the increasing maturity of the infant) builds to an ego that is the summation of an intricate and necessary developmental process. Key to this summation is the specialized environment in the very beginning of an infant's life which Winnicott has called primary maternal preoccupation.

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7 Ego distortion in terms of True and False Self

(1960)

Winnicott, D. W. (1960). Ego distortion in terms of true and false self. In *The maturational processes and the facilitating environment: Studies in the theory of emotional development* (pp. 140–152). London: Karnac, 2007.

In this paper, Winnicott presents the problem of what happens when an infant's primary caregiver (mother) cannot adapt well enough to the infant's needs and gestures. The infant must accept whatever he is getting, however *divergent* from his needs and signals that may be. The infant, then, is in the position of having to comply with the demands of the environment rather than having the environment comply with his needs and demands. As such, he is forced into building up a False Self with a false set of *compliant* needs and *compliant* responses, leading to a false relationship with both the mother and outside world. All of this is a contortion of his True Self, which, by these tactics he manages to hide from the outside world—and in some cases, from himself. The False Self, though it may be "well set up"—and though it may seem to be functioning quite well in life—lacks a certain something which Winnicott identifies as *essential*: the element of creative originality. It can also evidence itself, according to Winnicott, in the feeling that one has not started to exist.

Although Winnicott himself developed the language of True and False Self, he begins his paper with a bit of a disclaimer:

> 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.

Winnicott then moves on to present a bit of history, but as usual, is sparse in terms of direct citations of prior theorists: