D.W. Winnicott
'The Maturational Processes and the facilitating Environment'

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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.*, **41**, 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 psycho-analyst'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 psycho-neurotic 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].

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