

Beneath the Mask: **An Introduction to Theories** **of Personality**

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Klein had sustained many losses: her sisters Sidonie and Emilie, brother Emanuel, mother Libussa, husband Arthur. She would eventually lose two of her children: Melitta by embittered alienation and Hans in a hiking accident that led to his death in 1934, at the age of 27. She had weathered many conflicts and controversies: her marriage to Arthur, her clash with Anna Freud, and the attacks of her own eldest daughter Melitta in later years.

Melanie outlived Arthur by 20 years. Arthur Klein died in Switzerland in 1939. Melanie Reizes Klein died in London on September 22, 1960.

The Implications of Klein's Personal Sources

Melanie Klein described the development of human character with the earthy vocabulary of love and hate, envy and triumph, guilt and reparation. What links can we detect between Melanie Klein's theory and Melanie Klein's life?

Melanie's experiences with the dominating and intrusive Libussa Reizes surely fueled angry feelings in her. The utter detachment of the nearly invisible Moriz Reizes could only facilitate Libussa's fabrication of the Reizes matriarchy. Melanie's yearning for a competent father was thus thwarted equally by the very different behavior of both parents. Her mother and brother, each for their own selfish reasons, convinced Melanie that she had been an "unexpected" child and the "heaviest burden" to her mother. Like so many theorists we examine in this book, Klein felt unwanted. Rejection, too, breeds anger. Melanie Klein's understanding of the infant's mental life was thus captured—some would say "constrained"—by emotions derived from insecurity, frustration, threat, and conflict.³ Klein's inferences about the nature of human nature bear the imprint of this unique vision. Kleinian infants are more angry than curious, more anxious than eager, and impelled more by hate than by love.

As an adult, Melanie's experiences with her own children led to the discovery that mothers can be seen as evil, devouring witches, or as trustworthy, comforting companions. As Pasteur pointed out, "chance favors the prepared mind." Melanie had been well primed. The concept of mother-as-evil-devouring-witch was not entirely unprecedented in her experience and not all that difficult to accept. She understood that the maternal phantasy image created by children was determined in large part by the character of the relationship between mother and child at that moment in development. And so it must be, she reasoned, for all children. There can be little doubt that Melanie applied this reasoning to her own conflicted feelings toward Libussa, and thereby insulated her mother from a great deal of anger. Used in this way, the concepts of phantasy and split objects are both theoretical constructs and personally protective rationalizations.

Klein's belief that she had been the unplanned and begrudgingly loved child among her more favored siblings instilled a motive beyond anger. We will see the same motivation again among other personality theorists who felt unwanted as children and in the search for self-knowledge and healing chose psychology or psychiatry as their life work. For Klein specifically, the path to psychoanalysis was paved with chronic depression and intolerable feelings of unworthiness. She was especially alert

³ Chapter 18 presents a detailed comparison of the theme of unwantedness among the theorists.

to those feelings in others. If anger is the first reaction to feeling unwanted or inferior, the second is curiosity. Creative thinkers transcend the immediate grievance to question the meaning of what they experience. Such people, and Klein was certainly one of them, want to know if others share similar personal pain, and if so, *how* is it similar? Klein found herself focusing on this version of the puzzle: How can relationships with others be so contradictory? It was clear to her that even the earliest relationships generate pleasure with pain. They generate chaos and thereby instigate a need for order. Relationships trigger rage, but rage provokes guilt and anxiety. Love and admiration put the infant on the fast track to envy. These contradictory experiences were the ones Melanie Klein knew best and most intimately, and she chose to universalize them.

Klein's understanding of the infant's anger had eventually to be tempered by her more mature grasp of the child's complex world. The nuances and complexities of real children and the real distresses of her own relationships combined to moderate Klein's earliest, overly narrow obsession with infantile anger. Because parents are enviable for their superior power and knowledge, the child admires and envies them. In time, she recognized the child's need—and her own—not merely to destroy love objects, but to surpass them and bask in triumph until fleeting exultation yields to remorse.

She understood from experience the exquisite complexity of object relations. For example, the mother she loved and admired had nevertheless dominated and manipulated her. More painful still, Libussa contributed substantially but covertly to the failure of Melanie's marriage. Emanuel Klein, the much admired but fatally vulnerable brother, evoked taboo feelings in her. Their adult brother-sister relationship is described by Klein's chief biographer as all but overtly incestuous (Grosskurth, 1986, pp. 31 ff.). As a mother herself, she was often depressed and distracted, with the apparent result that her children created angry phantasies about her. As she had experienced her own mother, Melanie Klein must have been experienced as intrusive and manipulative by those of her children she employed as psychoanalytic patients. And their anger at having a mother who sometimes, frustratingly, was not a mother wrote profoundly influential passages in Klein's notebook of observations. It is small wonder that Klein proposed the fear of being attacked, devoured, or annihilated by mother as the fundamental and universal danger situation among women as compared with castration anxiety in men.

A FINAL WORD ON MELANIE KLEIN

Melanie Klein learned from her own relationships that the people to whom one is most attached are also the people who can provoke the most profound anger and the deepest envy. Hatred of one's nearest and dearest intimates inevitably leads to guilt. More painful still, when these people are gone through death or alienation, there is no recourse. Envy of love objects and triumph over them exacts a price. Only the residue of unresolved guilt grounded in the finality of loss remains constant. The need to protect them, one is compelled almost to say, "maternally," arises without logic, in spite of reason, guiltily from unmediated emotion. The raw power of feeling, not reason, is at the heart of the Kleinian worldview. In her emphasis on the irrational alone

is a compelling explanation of Melanie Klein's insistence on chaotic infantile phantasy, aggression, love, and guilt-driven reparation.

D. W. WINNICOTT

"MAY I BE ALIVE WHEN I DIE."

Pediatrician turned child analyst, Donald Woods Winnicott (1896-1971) brought common sense and a wry spontaneity to the treatment of children. Compared to such luminaries as Melanie Klein and Anna Freud, D. W. Winnicott was restrained in his rhetoric, pragmatically playful in his clinical style, and fiercely protective of his intellectual independence. Above all other qualities, Winnicott was gifted in the art of communicating with children. He could be playful with youngsters, even ironic, without patronizing them. And he had the knack of "holding"—making them feel safe.

Compared with the Kleinian child, still fresh in memory, the Winnicottian child is a collaborator not an antagonist (Phillips, 1988, p. 52). Winnicott positioned himself as a sympathetic witness to a child's distress, acknowledging a child's need for "holding" in both realistic and metaphorical ways. In short, Winnicott was a good mother to his patients. A measure of the man can be had in three anecdotes. The first provides a glimpse into Winnicott's down-to-earth, use-what-you-got technique with children. The second displays the ineffable Winnicottian charm, a graceful mix of whimsy and wit that struck sparks from flint. The third provides a front row, center seat at a matinee performance of the flinty side of Winnicott's character, a personal style that, for all its playfulness, was provocative and contentious.

The Squiggle, the Spatula, and the Niffle

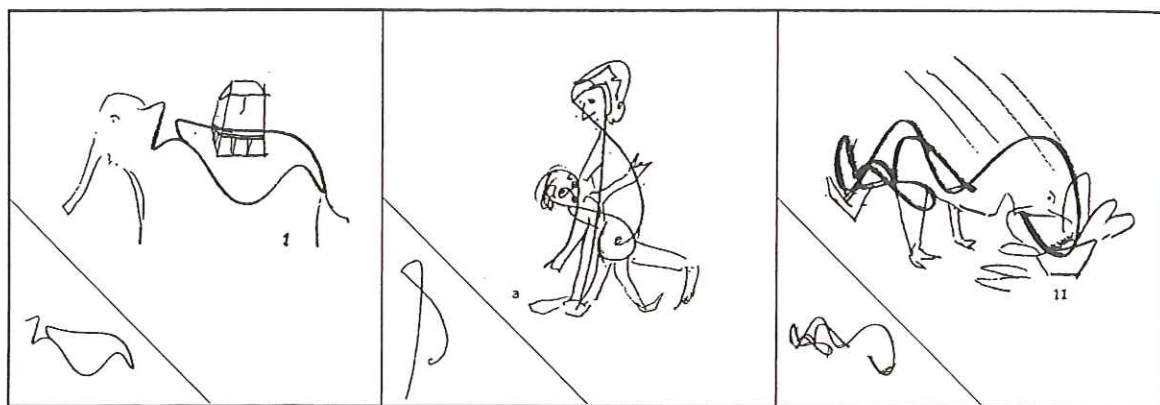
Winnicott drew a random-appearing line or an elaborate but ambiguous doodle on paper. He then invited a child to "make something" from this squiggle while encouraging the child to talk about the drawing and what it might mean. Then it was Winnicott's turn. The child was encouraged to create a squiggle which Winnicott, who had some talent for drawing, could turn into a meaningful picture. Of course, Winnicott's creations were often better than anything the child could accomplish with squiggles, and he was not reticent about pointing out this fact. Figure 5.10 illustrates Winnicott's use of squiggles with 12-year-old Patrick.

Winnicott sometimes enjoyed completing the child's squiggle with a wry or comic picture accompanied with humorous comments or even patently absurd, Dr. Seuss-like word play. On one occasion, for example, each time a child rose to place her latest squiggle drawing at the end of a row of pictures on the floor, Winnicott said "goodbye." She was greeted almost immediately with a Winnicottian "hello" as she returned to her seat beside him (Winnicott, 1964b, p. 308).⁴ In another instance,

⁴ Because his papers have appeared in so many overlapping collections at different periods in his career, the original publication date of Winnicott's work is cited wherever possible to permit the reader to follow the chronology of his thinking.

FIGURE 5.10 Squiggle Drawings of a 12-Year-Old Boy.

Patrick made the elephant in the left frame (1) from a squiggle drawn by Winnicott. The middle frame (3) shows Winnicott's transformation of Patrick's squiggle into what Patrick called "mother holding a baby." Sometime later, Patrick made the unusual picture on the right (11) from Winnicott's squiggle. He described it as person "who slipped into some dog food," and was probably mocking someone, perhaps Winnicott. The bottom corner inset of each frame shows the probable outlines of the starting squiggles, which are more apparent in the originals as variations of line density.



(From Winnicott, 1965b, pp. 344, 346).

Winnicott interpreted a child's squiggle as defecation products, calling it a "busy" in the peculiar idiom of the girl's family.

She looked at me as if it was interesting, but as if I was talking a language that was not hers, and she said it was a snake. So I put a plate round it and I suggested that we could have it for lunch. (1964b, p. 307)

Squiggle by squiggle, Winnicott permitted the child to tell the story of his or her world without hurry, often disjointedly, always interactively. After several "consultations" with Dr. Winnicott, inhibited children learned to work through play.

The Spatula

With infants, Winnicott invented a different but equally creative technique to enable them to communicate. The waiting room outside his office in the Paddington Green Hospital was often full to bursting with mothers and their infants. One by one, they entered Winnicott's consulting room to make a rather lengthy walk from the door to the desk and chair where the mother was invited to sit with her infant on her lap. The long walk provided Winnicott with an opportunity to observe the mother's handling of her child and the demeanor of both as they entered for the "consultation."

He then invited the mother and her infant to sit together next to a table on which he had placed a shiny, steel tongue depressor called a "spatula." Winnicott instructed the mother and any observers present in precisely how to behave, especially about the necessity to restrict their natural eagerness to prompt the infant.

... I ask the mother to sit opposite me with the angle of the table coming between me and her. She sits down with the baby on her knee. As a routine, I place a right-angled shining tongue-depressor at the edge of the table and invite the mother to place the child in such a way that, if the child should wish to handle the spatula, it is possible. Ordinarily, a mother will understand what I am about, and it is easy for me gradually to describe to her that there is to be a period of time in which she and I will contribute as little as possible to the situation, so that what happens can fairly be put down to the child's account. You can imagine that mothers show by their ability or relative inability to follow this suggestion something of what they are like at home; if they are anxious about infection, or have strong moral feelings against putting things to the mouth, if they are hasty or move impulsively, these characteristics show up. (1941/1992, pp. 52-53)

Over time, Winnicott's "set situation," as he called it, grew into a situational personality assessment of mother and child. Despite Winnicott's explicit instructions to remain silent and motionless, some mothers were unable or unwilling to accept the discipline of the situation. He observed, for example, mothers who "have a rooted objection to the child's mouthing and handling of objects. . . ." and communicated their disgust to their infants in subtle and not so subtle ways. Impulsive-anxious mothers, by comparison, could not restrain their eagerness to reassure and comfort their babies. Such over-eager reassurance often had the paradoxical effect of interfering with the child's spontaneous efforts to cope with the novelty of the situation. The set situation was seen as a test of intelligence by competitive mothers. Eyes on the prize, these mothers intrusively coached and prodded their infants toward "success" in grasping the spatula (1941/1992, p. 59).

In fact, the spatula game was a kind of test, but the primary subjects were the children. Winnicott used the set situation of mother, child, pediatrician, and spatula as a near-standardized but fundamentally projective assessment of infants' cognitive and emotional functioning. He described a three-stage sequence of "normal" behavior he had observed in the set situation with infants ranging in ages from four to 13 months. The beginning phase, called the *period of hesitation*, is one of initial stillness and expectancy with little overt action. In the second stage, the infant grasps the spatula and exhibits confidence and satisfaction in taking possession of and exerting control over the enticing object. Finally, the infant becomes playful, deliberately dropping the makeshift toy to hear it clang on the floor. Some infants in this third stage even engage the collaboration of an adult to "lose" and "find" the dropped spatula repeatedly. Table 5.2 provides a more detailed summary of a typical child's progress through the three stages.

Winnicott thought that the first stage in Table 5.2, or *period of hesitation*, was especially significant in revealing infants' typical emotional reactions in unfamiliar situations. Most infants already have a characteristic way of handling curiosity in the face of anxiety, and that temperamental style is manifest in the set situation. For most normal infants, the period of hesitation can be more precisely described as a moment of expectation. The infant who spies the shiny spatula is at first very still, very alert. Most youngsters restrain the impulse to reach for it immediately. They wait warily. Normal infants, Winnicott observed in thousands of instances, rapidly overcome their initial hesitancy because desire and curiosity grow more intense than anxiety. To all appearances, normally curious infants are struggling with inner resolve: "I could just

TABLE 5.2 Behavior of Normal 4–13 Month Old Infants in Winnicott's "Set (Spatula) Situation"

Stage	Infant Behavior	Evidence of Anxiety
1. Period of Hesitation (<i>Expectation and Stillness</i>)	<ul style="list-style-type: none"> • Holds body still. Expectant but not rigid. • Touches spatula, hesitantly, warily. • Wide-eyed with expectation, watches adults. • Sometimes withdraws interest and hides face. • Momentary hesitation to summon courage and accept reality of own desire to touch the spatula. 	Inhibited. Buries face in mother's lap. Ignores spatula completely or immediately seizes and throws spatula.
2. Confident and Collaborative Play (<i>Possession and Control</i>)	<ul style="list-style-type: none"> • Reaches for spatula decisively. • Excitement and interest mirrored in changes in baby's mouth: inside becomes flabby, saliva flows copiously, tongue looks thick and soft. • Explores spatula with mouth. • Free/flexible body movements linked to the spatula. • Exhibits confidence that he/she possesses the spatula and is in (magical?) control of it. • Plays with spatula, bangs it on table or on nearby metal bowl to make as much noise as possible. • Wants to play at being fed with adult as collaborator, but is upset if adult "spoils" game by really taking spatula into mouth. • Not obviously disappointed that spatula is inedible. 	Persistent, prolonged hesitation. Brute force needed to bring spatula close to infant or put it in baby's mouth with resulting distress, crying, colic, or screaming.
3. Riddance and Restoration (<i>Loss and Return</i>)	<ul style="list-style-type: none"> • Drops spatula as if by mistake. • Pleased when it is retrieved. • Deliberately drops it after restoration. • Enjoys aggressively getting rid of spatula, especially if it makes sound when dropped. 	Persistent (compulsive) repetition of riddance and restoration, with no evidence of boredom or waning interest.

(Based on the description in Winnicott, 1941/1992).

look at it. I should grab it. Maybe I shouldn't? But I *could*. I want it. I *will*." As self-confidence grows, action replaces indecision. Delight displaces delay. Anxiety evaporates. The prize is seized. Drooling and cooing accompany the spatula as it enters baby's mouth for an examination unlike anything intended by the designer of the tongue depressor.

Winnicott also observed that acutely anxious infants were unable to master their hesitation and prolonged their delay indefinitely. In contrast, some anxiously impulsive infants circumvented the period of hesitation altogether and immediately seized the spatula to throw it to the floor. When Winnicott wrote his first paper describing this deceptively simple observational technique, he was still in the early phases of learning about child psychoanalysis. Melanie Klein's ideas loomed large in Winnicott's training, and he attempted to interpret the symbolic meaning of the spatula for the child. He hypothesized that the spatula signified to the infant a breast, a penis, and even a person or "bits" of a person (1941/1992, p. 61). Fortunately, Winnicott's empirical predilections and good sense eventually prevailed over his enthusiasm for

Kleinian speculations. He could see that the "set situation" was a window on the infant's interpersonal transactions and emotional maturity:

In the set situation the infant who is under observation gives me important clues to the state of his emotional development. He may only see in the spatula a thing that he takes or leaves, and which he does not connect with a human being. This means that he has not developed the capacity, or he has lost it, for building up the whole person behind the part object. Or he may show that he sees me or mother behind the spatula, and behave as if this were part of me (or of mother). In this case, if he takes the spatula, it is as if he took his mother's breast. Or, finally, he may see mother and me and think of the spatula as something to do with the relation between mother and myself. In so far as this is the case, in taking or leaving the spatula he makes a difference to the relationship of two people, standing for father and mother. . . . The infant, if he has the capacity to do so, finds himself dealing with two persons at once, mother and myself. This requires a degree of emotional development higher than the recognition of one whole person, and it is true indeed that many neurotics never succeed in managing a relation to two people at once. (Winnicott, 1941/1992, pp. 64-65)

The Niffle

Tom, age five, was injured while on vacation with his family and evacuated to a distant city to be hospitalized. His mother accompanied him, but eventually left Tom alone in the hospital, where he found it hard to sleep without his "niffle." Tom's niffle, so named by his sister, was a square of woven material derived from a wool shawl. In fact, there had been three niffles, but only one of them was Tom's special niffle. He could distinguish his special niffle from the other two even in the dark (Winnicott, 1996a/1996, p. 105). Returned home, Tom's mother tried to ship the special niffle to her son's hospital, but the niffle failed to arrive and was never seen again.

Eventually Tom recovered and rejoined his family, but he seemed not to be the same child. He became oppositional toward his mother, and resisted being dressed and cleaned by her. Tom acted in a "generally annoying way" and spoke with a peculiar high-pitched voice that sounded girlish. Tom's mother was especially irritated by this voice. When questioned by Winnicott, Tom summed it all up: "But I wish I had this little niffle. It makes me feel . . ."—at which point Tom was at a loss for words. Fortunately Winnicott did not share Tom's loss, but understood the betrayal he was feeling and the angry mourning reaction he was experiencing.

We have all seen children attached to their teddy bears, comforted by soft blankets they drag around with them, and their delight in other cuddly things; but until Winnicott ventured into the field it is doubtful that anyone understood the child's active creation of attachment magic with these things. Winnicott intuitively grasped that the teddy bears, blankets, and niffles of this world are *transitional objects* that bridge the gap between the child's utter dependence on its mother and its profound need to progress to independence. Tom's missing niffle was experienced by him as a profound loss of love, security, and trust. Winnicott understood what Tom's mother did not, and he taught the rest of us that a niffle is not a trifle.

Winnicott clearly had the spontaneity, creativity, and playfulness to adapt ordinary activities and materials to the psychoanalytic task of interpreting the child's inner world. It is no small matter, as we shall see, that Winnicott's choice of the tongue

depressor/spatula as one of his diagnostic instruments had the subtle consequence of emphasizing his professional and personal links to medicine. He nevertheless used this "doctor-tool" in the most "un-doctor" ways. Winnicott consolidated the observations that he made with this traditional instrument of pediatric physical examinations into the most untraditional of pediatric psychological assessments. It is important, therefore, not to underestimate how much Winnicott prized his originality and protected his independence. As a pediatrician/child psychiatrist, Winnicott worked hard to be seen as an innovator. It was no less important to Winnicott to be steadfastly, not to say defiantly, original as a psychoanalytic psychiatrist. It is a virtual certainty that Winnicott would be pleased to know that, among his other accomplishments, he is remembered as the theorist of the squiggle, the spatula, and the niffle.

The Pill for Folks Not Ill

Late in his career, Winnicott delivered an invited but informal talk to the members of the Progressive League entitled "The Pill." His opening remark was pure Mark Twain: "Actually, you know, I've never had the Pill" (p. 195). He then described how he tried to prepare for the talk, but instead of an organized outline, he managed to create only the following poem (Winnicott, 1969a/1986, pp. 196-97):

O silly Pill for folks not ill!
 Why not wait till you know God's will?
 What's empty will in time refill
 And pregnant hill be razed to nil.
 Men! Have your will, put Jack in Jill;
 Girls! Drink your fill of his chlorophyll.
 Fear not the spill you know the drill,
 You know a still and silent kill . . . the Pill.
 So take my quill I sure will:
 Don't dally dill with silly Pill,
 Just wait until what happens will!
 Then pay the bill.

Winnicott's audience delighted in his humor, whereas a contemporary audience would probably polarize into armed camps.

"I died."

Toward the end of his life, Winnicott began preparing an autobiography, fragments of which have been published in the reminiscences of Clare Winnicott (1978; 1989). On the inside cover of a notebook, he copied several lines from T. S. Eliot⁵ and followed

⁵ The lines Winnicott quoted were from T. S. Eliot's *Four Quartets* ("Little Gidding") and reflect Winnicott's lifelong affinity for paradox and dialectical thinking:

Costing not less than everything
 [and]
 What we call the beginning is often the end
 And to make an end is to make a beginning.
 The end is where we start from.

them with this prayer: "Oh God! May I be alive when I die." Immediately thereafter, Winnicott begins his autobiography: "I died." Not one to prolong the suspense, a few lines later Winnicott tells his readers that his prayer was answered, "I was alive when I died. That was all I had asked and I got it" (quoted in C. Winnicott, 1989, p. 4; see also C. Winnicott, 1978, p. 19).

UNCONVENTIONAL PSYCHOANALYSIS: THE PEDIATRIC CONSULTATION MODEL

Winnicott's primary professional training was in pediatrics. Throughout his career, even after years of preparation as a child analyst, Winnicott thought of himself as both a pediatrician and a psychoanalyst. Each professional identity, he believed, informed and enhanced the activities of the other (e.g., Winnicott, 1965a, pp. 140-141; Kahr, 1996; Phillips, 1986). In so doing, Winnicott found that he had become the proverbial man without a country, citizen of neither domain. As a pediatrician, Winnicott encountered the "unwillingness" of his medical colleagues to consider the psychology of physical illness. And a pediatrician of the late 1920s who took seriously the psychology of the unconscious was simply not a pediatrician (Winnicott, 1931/1958, p. 20). As a child analyst, Winnicott was expected to leave pediatric medicine and all its traditions behind. The analyst does not take detailed histories of the patient and patient's family, does not physically examine the patient, nor does the analyst directly observe the child-rearing environment provided by the parents. Above all else, the child analyst does not serve as a consultant who briefly sees a child in one or two sessions to provide child-rearing advice to the parents or make focused, often educational, interventions (Winnicott, 1963a/1965a; 1958/1965c). Such forays outside the analyst's traditional role were simply not done.

Winnicott did them. "I am a paediatrician who has swung to psychiatry," Winnicott wrote, "and a psychiatrist who has clung to paediatrics" (1948c/1992, p. 157). He sought nothing less than a personal synthesis of two antagonistic traditions. Compounding two disparate professions into one had the most welcome side effect of conferring an aura of originality on both. With originality came the added blessing of intellectual independence. Successful management of this novel, not to say subversive, blending of clinical roles elevated Winnicott to a unique position in medical and psychiatric circles. He became *the* pediatric child analyst (see Jacobs, 1995 for a similar view; and Phillips, 1988, pp. 48 ff.; Winnicott, 1971, "Introduction").

And the rich grow richer. Winnicott's singularity among child analysts caught the attention of Ernest Jones, the head of the British Psychoanalytic Society. In a 1936 letter to Freud, Jones described Winnicott as "our only man [child] analyst" (Freud and Jones, 1993, p. 755). Had he known, Winnicott would have been amused, then pleased. He abhorred following the crowd in anything.

Elements of a Winnicottian Consultation

Much of Winnicott's experience was gained in relatively brief consultations with parents and children, especially during the war years, and frequently in a hospital clinic setting. In these consultations, Winnicott provided a number of services, including

diagnosis, advice on childcare, and recommendations for placement or specialized treatment. Khan (1975/1992, p. xvii) places the number of children and family members seen by Winnicott in consultation over a period of four decades at an amazing sixty thousand. Winnicott (1948c, p. 158) himself reported that he had personally taken histories from over twenty thousand mothers.

Although Winnicott (1972/1986; Little, 1990) conducted a fair share of the more traditional one-on-one "analyses," his pediatric training and personal preferences steered him in the direction of a consultative style characterized by precision focus, rapid tempo, and brief duration. Such encounters, sometimes episodically repeated, might consist of a single "diagnostic-history-taking-recommendation-session" or a series of comparatively leisurely meetings with a child, typically over the span of several weeks or months, but sometimes extending for years (Winnicott, 1957/1965c). Only the tiniest fraction of the children with whom Winnicott consulted were viewed as appropriate candidates for "standard" psychoanalysis. Straddling the two worlds of pediatric psychiatric consultation and child psychoanalysis demanded that Winnicott develop a singularly flexible perspective. The real world constraints of distressed children, and the living conditions provided for them by their parents, achieved special significance in Winnicott's thinking. A composite picture of the Winnicott consultative method highlights these techniques and assumptions.

Take a History, Make a Diagnosis

Winnicott was a bear about taking a detailed family history. His medical training persuaded him that children were people who could be understood only when a complete and chronologically ordered narrative of the child's life had been constructed. The clinician had to take the time to piece together the fragments of confusion that often blurs the meaning of the child's "symptoms." Simply disentangling the facts from the confusions was often therapeutic enough. Such history taking included the usual elements of presenting problem, chronology of developmental landmarks, parental descriptions of the child's problem, the child's description of the problem, and sometimes even direct observation of mother and child (or father and child) playing together. But the purpose of taking the history was not the mere gathering of data:

It was as a practicing 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. (Winnicott, 1963a/1965a, pp. 198-99)

Diagnosing the patient's difficulty correctly was a central feature of Winnicott's work. His diagnosis began by taking the patient's history, but continued throughout their work together. Changes in the patient's behavior, alterations to the patient's circumstances, and "spontaneous" modifications in the nature or quality of the therapeutic relationship signaled Winnicott to alter his diagnosis and sometimes his therapeutic strategy. One size, Winnicott believed, does not fit all: "... by and large, analysis is for those who want it, need it, and can take it" (1962a/1965a, p. 169).

Take Charge, Take Notes, Take Your Time

From the vantage point of medical practice, Winnicott was a firm believer in taking charge of the consultation. As both a pediatrician and as a psychodynamic psychotherapist, Winnicott assumed that it was his responsibility to provide a setting in which both the child and parents felt safe enough to communicate the meaning they placed on the child's distressing symptoms. The responsibility of the clinician is to be reliable, truthful, calm, and authoritatively knowledgeable (Winnicott, 1961b/1990, p. 235).

Use What You Got, as Little as Needed, as Simply as Possible

For many consultations, Winnicott was creative in enlisting the aid of the child's parents, teachers, or caseworker to carry out "treatment" in the child's daily environment. As Winnicott pointed out, "In psychoanalysis we ask ourselves: how much can we do? At the other extreme, in my hospital clinic, our motto is: how little need we do?" (1961b/1990, p. 233; 1962a/1965a, p. 166). Winnicott was sensitive to the need for economy and efficiency in the treatment of childhood disorders, a sensitivity that he carried over into his psychoanalytic practice as well (Winnicott, 1955/1989). Even when working analytically, Winnicott strove to make his interpretations as brief as possible. He even limited himself to one interpretation per session, unless he was very tired (1962a/1965a). He did not hesitate to mix "standard" analytic method with other procedures that met the needs of specially primitive patients. In a very unanalytic way, he sometimes intervened directly into the patient's daily life. He aimed to provide more stability and security for those who functioned especially precariously or who exhibited the special needs of people with primitively organized personalities (e.g., Little, 1990).

Don't Be Eager to Be Clever. Shut up. Let the Patient Talk.

Winnicott learned a lesson unusual in medical education from a teacher of pediatrics—Dr. Thomas Horder—at St. Bartholomew's Hospital. The lesson was to listen to his patients. Horder told Winnicott "Don't you go in with your wonderful knowledge and apply it all. Just listen. They'll tell you quite a lot of things. You'll learn if you listen" (C. Winnicott, 1983/1991, pp. 188–89). Winnicott took the advice both for his pediatric consultations and, later, for his approach to psychoanalysis. He tried to restrict himself to one or at most two interpretations in a single session. When he was tired, he sometimes found himself talking too much in analytic sessions. At such times, he described himself as having drifted into a "teaching session" rather than "doing psychoanalysis." He even quipped that whenever he found himself using the word *moreover*, he knew he had drifted again (Winnicott, 1962a/1965a, p. 167). As Winnicott put it toward the end of his life,

If only we can wait, the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more than I used to enjoy the sense of having been clever. *I think I interpret mainly to let the patient know the limits of my understanding.* (1968b/1989, p. 219; emphasis added)

Normal Life Is Normally Difficult. Symptoms Are Easier.

Winnicott recognized that a child's aberrant behavior often had multiple "uses" in the child's world. Symptoms can have various meanings that are not always "abnormal" even when extreme. Bed-wetting, for example, is

... a common enough symptom which almost everyone has to deal with who has to deal with children. If by bed-wetting a child is making effective protest against strict management, sticking up for the rights of the individual, so to speak, then the symptom is not an illness; rather it is a sign that the child still hopes to keep the individuality which has been in some way threatened. In the vast majority of cases, bed-wetting is doing its job, and given time, and with ordinary good management, the child will become able to leave off the symptom and adopt other methods of asserting the self.

Or take refusal of food—another common symptom. It is absolutely normal for a child to refuse food. I assume that the food you offer is good. The point really is that a child cannot always *feel* the food to be good. A child cannot *always* feel that good food is deserved. Given time and calm management the child will eventually find out what to call good, and what to call bad; in other words, will develop likes and dislikes, as we all do. (Winnicott, 1964a, p. 127; emphases in original; see also 1964c)

Normality is maturity; abnormality is immaturity (Winnicott, 1958/1965c, pp. 101–03; 1961a/1989). Sometimes, Winnicott argued, the most efficacious thing the child therapist can do is nothing. Waiting for the child's growth and maturity to attenuate the problem is often the pediatrician's/therapist's best strategy, and Winnicott often advised parents to do the same. Active intervention in what appears to be seriously pathological behavior is sometimes not necessary if the parents can provide an adequate and loving environment for the child to master its momentary distress.

A normal child can employ any and all of the devices nature has provided in defence against anxiety and intolerable conflict. The devices employed (in health) are related to the kind of help that is available. Abnormality shows in a *limitation and rigidity* of the child's capacity to employ symptoms, and a relative lack of relationship between the symptoms and what can be expected in the way of help. (1964a, p. 126–27; emphases in original)

Winnicott's point, drawn from his pediatric medical experiences, was that "symptoms" are often indicators of the healthy child's ability to battle against disease and other adversities. Only when a child's "symptoms" are linked to failure of the child's natural defenses can we assume the presence of "abnormality."

So, although bed-wetting, and refusal of food, and all sorts of other symptoms can be serious indications for treatment, they need not be so. In fact, children who can surely be called normal can be shown to have such symptoms, and to have them simply because life is difficult, inherently difficult for every human being, for every one from the very beginning. (Winnicott, 1964a, p. 127)

Why Normal Life Is Difficult: From Illusion to Disillusion

Under the best of circumstances, the developing infant confronts and must master a succession of disappointments. First, Winnicott pointed to the child's experience of the clash between its inner world of fantasy and the outer world of reality. With varying

degrees of disappointment, babies learn that what is wanted is not always what is supplied. The illusion of wishfulness are inevitably disillusioned by the facts of reality (1964a, p. 128).

Second, babies learn that destructive urges and thoughts that are frightening sometimes accompany the feeling of excitement (1964a, p. 128). As the infant slowly recognizes and increasingly loves the person who supplies food, care, and affection, its spontaneous urges to devour and use up the good it receives from that person become increasingly troubling. "And, along with this, there comes a feeling that there will be nothing left if everything has been destroyed; and what happens then, should hunger return?" (Winnicott, 1964a, pp. 128-29). Consequently, the baby's eagerness for food disappears. The "symptom" of inhibition has replaced the infant's healthy greediness for food. Wise mothers intuitively know that simply "playing for time" is the necessary and sufficient intervention to make in these circumstances.

Third, the infant quickly discovers a new source of life's difficulties. "Only too soon, added to other troubles are those that belong to the child's recognition that there is also father to be reckoned with" (Winnicott, 1964a, p. 129). Perhaps, the discovery of siblings adds additional fuel to the fire. Jealousy rears its ugly head. The illusion of exclusive possession of mother dissolves into the disillusionment of a shared, sometimes unavailable, love object.

Fourth, the child's inner world of imaginary friends and foes, fantastic fairies and animals, and magical battles won and lost is an illusion that the child can omnipotently control. With time however, the stresses and strains of controlling this inner world are revealed in all manner of bodily aches, pains, and upsets (Winnicott, 1964a, p. 130). Transformed into an apparently possessed creature, the child indeed is possessed by the real and imaginary people from within making their way into the outside world. Aches, pains, and upsets are normal reflections of internal ups, downs, triumphs, and failures. The wise mother and father support the child's struggle to reconcile inner and outer worlds. They might, for example, acknowledge that they, too, could see the imaginary friend. Providing care for "both" children thereby demonstrates to one of them that life is doable, parents do understand, and imaginative play need not be shameful. Setting a place at the table for the friend, or at bedtime even tucking child and companion in for the night strikes some as pandering to the child's eccentricity, but the alternative is to invalidate the child's healthy childishness. Hence, parents who scoff at their child's imaginary world and its creatures are prematurely expecting maturity.

In Winnicott's description of it, life is hard. Early experiences are fraught with difficult things to learn, and often evoke disappointment because disillusionment is unavoidable. Such experiences, however, are normal, and momentary signs of psychological distress are not indications of abnormality. The degree to which a child remains sufficiently able to be playful through all of the adversities and disappointments of early life is the measure of that child's normality.

Commitment to Pediatrics

Clearly, Winnicott's early papers were blends of pediatric medical advice, Dr. Spockish admonitions to parents to trust their own abilities and those of their children, and psychological insights about development drawn from reading Freud (e.g., Winnicott,

1931a, 1931b, 1936, 1944). Winnicott had a wry, homey, avuncular style honed to perfection in his child care radio broadcasts during World War II. That same style, an entertaining and disarming mix of authority, wit, and soothing nurturance, continued to serve him well in print when his broadcasts were turned into papers and books (Winnicott, 1993, esp. Chapter 1). He was widely in demand as a speaker for medical, parent, and teachers' groups throughout his career, and he never failed to provide a humorous but psychological slant on seriously practical pediatric matters.

By the same token, however, Winnicott's commitment to his role as a pediatrician had important consequences for his theory of object relations. Pediatrics broadened his vision as a child psychiatrist and supported his intuitive and empathic grasp of child psychology. Pediatrics taught him patience with his patients. Most important, Winnicott was pragmatic, a psychoanalyst who recognized that life is difficult, and psychoanalysis cannot alter that fact.

The best that can happen is that the person who is being analyzed gradually comes to feel less and less at the mercy of unknown forces both within and without, and more and more able to deal in his or her own peculiar way with the difficulties inherent in human nature, in personal growth, and in the gradual achievement of a mature and constructive relationship to society. (Winnicott, 1945b/1996, p. 12)

With these foundations, Winnicott's natural reluctance to "follow anybody's lead" intensified. The result was an object relations theory that, more often than not, fabricates playful paradoxes from orthodox concepts and stands traditional ideas on their heads.

EARLY THEORY: THE KLEINIAN INFLUENCE

As much as Winnicott wanted his independence, the reality of psychoanalytic training in the 1920s and 1930s demanded at least publicly professed allegiance to the ideas of the movement's leaders. Anna Freud and Melanie Klein dominated the specialized branch of child psychoanalysis to which Winnicott aspired. Perpetually wary of intellectual entanglements and demands for orthodoxy, Winnicott found himself in the awkward position of having to choose between the frying pan and the fire. He chose fire.

At the outset of his psychoanalytic career, Winnicott incorporated a multitude of Kleinian and Freudian concepts into his understanding of child psychology. He had assimilated the "classic" formulations of Freud both from his reading and from his personal analysis with James Strachey (1887-1967), the eminent British analyst and Freud's chief translator. However, during the analysis, Strachey recommended to Winnicott that he seek out Melanie Klein to learn more about the application of psychoanalysis to children (Winnicott, 1962b/1965a). Winnicott took Strachey's advice and made contact sometime in 1932, about two years before the end of his analysis with Strachey (Kahr, 1996, p. 58).

Winnicott's View of Melanie Klein

Winnicott initially found that Klein's work provided important insights about emotional functioning at the very earliest periods of infancy. As we have seen, Klein was

almost daily pushing psychoanalysis to earlier and earlier periods of infancy. For a time, Winnicott found this Kleinian direction a congenial and enlightening path to follow. His own observations as a pediatrician had already paved the way for his ready acceptance of the idea that children could be "emotionally ill" with roots extending well before the oedipal period of ages five and six. Winnicott commented, "This was difficult for me, because overnight I had changed from being a pioneer into being a student with a pioneer teacher" (1962b/1965a, p. 173). Nevertheless, Winnicott recalled that Klein was an admirable teacher who could be surprisingly flexible and formidably attentive to the details of the cases he brought for supervision. Winnicott retained Melanie Klein as a clinical supervisor for the better part of six years, from 1935 to 1941 (Kahr, 1996, p. 59). More than 20 years later, Winnicott summarized the significance of his experiences with Melanie Klein in a capsule view of her importance to psychoanalysis:

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 the 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. (1962b/1965a, p. 176)

Winnicott nevertheless insists on his independence, although he admits to some small degree of disappointment:

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. (1962b/1965a, p. 176)

It is no surprise, then, that Winnicott's first "official" psychoanalytic paper was primarily an elaboration of—with subtle modifications to—one of Melanie Klein's central concepts. On December 4, 1935, Winnicott presented his membership paper entitled "The Manic Defence" to the British Psychoanalytic Society. Such presentations carried the weight of a commencement ceremony intended to mark the culmination of a candidate's long preparation in becoming a qualified psychoanalyst by admitting that analyst to full membership in the society.

Of course, the ritual was as much a political and professional rite of passage as it was a theoretical contribution. Ostensibly, candidates for membership were required to present "original" theoretical or clinical ideas, but the wise aspirant understood that the presentation had to be managed with the skill and tact of a diplomat. Covert but mandatory etiquette governed the proceedings. Applicants first had to demonstrate that their "original" ideas derived from Sigmund Freud's concepts. The master said it, said it first, and said it mattered. Somewhere. Somehow. As convoluted a task as that sometimes proved to be, proper execution of the commencement ritual, the

full Monty, so to say, demanded more. A candidate also had to acknowledge intellectual debts to the influential senior analysts in the candidate's area of specialization. Paradoxical as it seems, candidates mounted the podium eager to argue that their original ideas were derivative.

The Manic Defense: Inner and Outer Reality

Winnicott was master of this paradox. His "graduation paper" was a personalized reinterpretation of Kleinian concepts masquerading as debt acknowledgement (Winnicott, 1935/1992). Starting with the central Kleinian concepts of fantasy (i.e., phantasy) and the depressive position, Winnicott described how Klein helped him to distinguish among fantasy, inner reality and outer reality. Recall from our earlier discussion that a central aim of a person in the Kleinian "manic position" is to exert omnipotent control over external objects by magically manipulating their internalized or phantasized representations. The Kleinian infant believes that what is done to the phantasy object is done to the external object in reality. Because manic control is believed to be absolute, the infant can "devalue" powerful and persecutory bad objects into mere shadows of their former threatening selves, held in suspended animation between life and death.

Following Klein, Winnicott argued that fantasy—and he avoided the idiosyncratic Kleinian "ph"—is akin more to daydreaming and to ordinary imagination than to the processes of unconscious inner reality. With this subtle shift in perspective, Winnicott gives Klein's term new meaning:

... it is part of one's own manic defence to be unable to give full significance to inner reality. There are fluctuations in one's ability to respect inner reality that are related to depressive anxiety in oneself. (1935/1992, p. 129)

Winnicott artfully redefines the manic position to moderate Klein's emphasis on the absolute power of the internal world. He argues that the developmentally "normal" manic defense against depressive feelings compels the defender to minimize, not maximize, as Klein would have it, the influence of internal object representations.

Omnipotent fantasies are not so much the inner reality itself as a defence against acceptance of it. One finds in this defence a flight to omnipotent fantasy, and flight from some fantasies to other fantasies, and in this sequence a flight to external reality. This is why I think one cannot compare and contrast fantasy and reality. (Winnicott, 1935/1992, p. 130)

Sounds almost Kleinian. Might be Klein-friendly. Could be Klein-compatible. However, the core distinction between fantasies and inner psychic reality is not bona fide Klein. Winnicott was paving the way for a fundamental alteration to Klein's ideas. Recall his argument that normal life is normally difficult. He therefore simply asserted the importance of the role in development that ordinary reality plays. As a direct consequence, he normalized the pathological sounding—"manic" and "depressive"—developmental positions. Winnicott reasoned that manic defending is detectable in ordinary living inherent to the struggle all people make against the daily abrasions and sorrows of life:

For instance, one is at a music-hall and on the stage come the dancers, trained to liveliness. One can say that here is the primal scene, here is exhibitionism, here is anal control, here is masochistic submission to discipline, here is a defiance of the super-ego. Soon or later one adds: here is LIFE. Might it not be that the main point of the performance is a denial of deadness, a defence against depressive "death inside" ideas, the sexualization being secondary.

What about such things as the wireless [i.e., radio] that is left on interminably? What about living in a town like London with its noise that never ceases, and lights that are never extinguished? Each illustrates the reassurance through reality against death inside, and a use of manic defence that can be normal. (Winnicott, 1935/1992, p. 131)

For Winnicott, inner reality is an equal partner with outer reality, the world of ordinary life. "Life is hard," but that does not mean for Winnicott that strenuous coping with life's difficulties, including the struggle to feel alive in the face of death, is inevitably pathological. Winnicott thus depathologizes Klein's concept of manic defense by reframing it to encompass coping with life's unavoidable miseries. He elevates the external world to equal status with the inner world as a determinant of emotional development.

Depathologizing the Depressive Position: The Ruth and the Ruthless

In a later paper, he applied the same strategy to a fuller discussion of the Kleinian depressive position, more strongly emphasizing than did Klein herself the normal "achievement" of concern for the good object (Winnicott, 1954-55/1992). He proposed that the Kleinian term *depressive position* was a poorly conceived name for this essentially normal process, and suggested that *stage of concern* might better communicate the essence of the process. In subtle and not so subtle ways, Winnicott again normalized a Kleinian concept that implied greater abnormality than the typical infant exhibits. Winnicott agreed with Klein that the infant begins its relationship to the external object more or less "pre-ruth," that is, ruthless in attempting to satisfy its needs. With the whimsy of Lewis Carroll, Winnicott points out that the infant gradually passes from the pre-ruth stage to the stage of ruth. In more familiar, less whimsical English, the infant grows less ruthless and more able to feel concern and empathy for its love objects.

PRIMITIVE PERSONALITY DEVELOPMENT, WINNICOTT STYLE

Despite his obvious discomfort with the extremity of some of Klein's concepts, Winnicott nevertheless incorporated many of her ideas concerning psychological processes that hypothetically describe an infant's earliest days of life. Winnicott's own pediatric observations suggested that a series of important cognitive and emotional achievements had already unfolded in orderly progression prior to the stage of concern (i.e., Klein's "depressive position"). These capacities *must* develop in the first five or six months of life for the infant to be able to reach the stage of concern.

His observations of babies exploring the spatula had convinced him that infants of five months understood that the object for which they reach is localized in space "outside me." Furthermore, the baby who thrusts the spatula into its mouth is necessarily aware that there is an "inside me." Deliberately dropping the spatula demonstrates that "he knows he can get rid of something when he has got from it what he wants from it" (1945a/1992, p. 148). Parallel to these achievements, the infant of five or six months:

... assumes that his mother also has an inside, one that may be rich or poor, good or bad, ordered or muddled. He is therefore starting to be concerned with the mother and her sanity and her moods. In the case of many infants there is a relationship as between whole persons at six months. Now, when a human being feels he is a person related to people, he has already travelled a long way in primitive development. (Winnicott, 1945a/1992, p. 148)

Thus, Winnicott argued that Klein's depressive position includes cognitive and emotional developments that have nothing to do with defensive maneuvers against depression. Winnicott now set himself the task of describing what happens before the stage of concern at five or six months. The big question, he pointed out, is whether anything matters before five or six months. Winnicott's answer was that at least three important achievements mattered to a great degree: personality integration, personalization, and realization.

Personality Integration: From Muddled to Cuddled

Winnicott hypothesized that at the very beginning of life, personality is in a primal state of "unintegration." With absolute literalness, Winnicott meant that in the earliest days of life there is no *person* to embody an integrated personality. There is only a bundle of biological needs and potentials. "What is there is an armful of anatomy and physiology, and added to this a potential for development into a human personality" (Winnicott, 1968a/1987, p. 89). Unintegrated infants do not comprehend themselves or others as whole people and are not yet aware that others do so all the time. Personality integration begins quickly and spontaneously after birth, and requires two sets of experiences to go forward smoothly.

The first is the baby's own internal world of need and drive which by their infinite repetition become the stabilizing routines of life around which a personality can form. Need and drive are, in their ways, reassuring experiences that signal one is alive. As long as mother and other caretakers satisfy the infant's needs reliably, survival is not threatened, and the natural process of integration proceeds unhindered. The inexorable repetition of appetite arousal and satisfaction gradually grows familiar and welcomed.

The second organizing experience is the quality of the care the infant experiences. The baby is handled, bathed, fed, rocked, named, and called by name, and cuddled, and each of these repetitive events helps to bring order to internal confusion. From these scattered fragments of need, maternal response, cuddling, and predictable care, a gradual synthesis of identity emerges. "Me" and "not-me" begin to have meaning for the infant. Mother's "holding" her infant in ways beyond physical cuddling promotes comfort and stability. As Winnicott used the term, *holding* elevates cuddling to

a primary means of communication between infant and mother. Holding the infant securely in both the physical and psychological senses of the term enables the securely held infant to organize its muddled urges, wishes, and fears into predictable experiences. We return to a more complete examination of Winnicott's evolving concept of holding at a later point.

Personality integration continues to evolve with time, but the feeling of being "not quite whole" does not frighten the securely held infant. "There are long stretches of time in a normal infant's life in which a baby does not mind whether he is many bits or one whole being, or whether he lives in his mother's face or in his own body, provided that from time to time he comes together and feels something" (Winnicott, 1945, p. 150). Later in development, however, specific developmental failures that can provoke regression to an unintegrated state—the experience of *disintegration*—is very frightening and often associated with psychotic-level psychopathology. Primordial "unintegration," however, is the natural state of newborns and infants up to five months of age. In contrast to the astonishing cognitive resources of a Kleinian infant, Winnicottian babies come equipped with more homely logic. Psychological anachronisms are found only rarely in their repertoire. Winnicottian youngsters can fear the loss of personal integrity only after they have had it.

We should note Winnicott's creative, but nonetheless idiosyncratic, use of opposites. As he employs the term, the opposite of integration is not disintegration but "unintegration." Unintegration indicates a naturally occurring starting point on the road to the final destination of integration. Disintegration lies on an altogether different conceptual dimension—the dimension of psychopathology—rather than occupying the opposite end of the same dimension as unintegration. Disintegration is pathological because it "is an active production of chaos in defence against unintegration in the absence of maternal ego-support . . ." (1962c/1965a, p. 61). We have also seen in passing Winnicott's use of illusion and disillusion. As we shall see in the next section, Winnicott created another concept by converting the standard psychiatric term *depersonalization* into its Winnicottian opposite: *personalization*. Dialectical thinking—formulating concepts by contrasting pairs of opposites—was one of Winnicott's favorite theoretical strategies.

Personalization: From Cleaning to Weaning

Satisfactory personalization leads to the feeling that the infant is "in" his or her own body. As with integration, biological need and maternal care guide the process of personalization so that the evolving personality has a "place" to reside. Mother's attention to physical care and cleanliness quietly helps the infant reach the understanding that he or she has a body, "resides" in it, and is sometimes in control of it. In short, the infant achieves *personalization*. Put another way, the infant particularizes its inventory of recognizable physical equipment by personalizing each component. The particular "person" is either self or not-self. This waving digit is *my* finger because I can make it go in my mouth for a good suck, but this digit tickling my tummy is not mine because I can't stop it. This wiggling pink thing that lies just out of reach is *my* toe, but this bigger one that I can reach—and bite—is not mine because I don't feel bitten and

because Daddy is doing the yelling. A very sore place I can feel but can't see is *my* tushy (bobo, heinie, butt, rear, tuchis) with *my* diaper rash.

Schizophrenic and near-psychotic people who abruptly feel uncomfortable with their own bodies or develop the delusion that they are not "in" their bodies sometimes experience the opposite phenomenon, called depersonalization. A less malignant variation of depersonalization is the belief that something is alarmingly and abruptly different, "not right," or "not real" about my body. However, the person frequently is unable to articulate the specific difficulty that he or she is experiencing. An even less malignant variation of depersonalization, in fact a common occurrence of childhood, is the creation of imaginary companions. Some children even use the imaginary companion as a magical defense to bypass the anxieties of childhood associated with eating, digestion, retention, and expulsion (Winnicott, 1945a/1992, p. 151).

Some primitive depersonalization phenomena, Winnicott hypothesized, have their roots in failures of the primary personalization experiences in infancy (1945a/1992, p. 151). Personalization, as Winnicott employed the term, is the achievement of a burgeoning personality attempting to complete the process of integration by taking possession of the body in which it finds itself and becoming increasingly comfortable with ownership.

Realization: From Dreaming to Scheming

The third early personality development is learning to take account of external reality. Rather than employ "reality testing," the standard psychoanalytic term, Winnicott chose to call this achievement *realization* (as a parallel to *personalization*?). He would later extend the list with a fourth process that emphasized "object relating," as we shall see. At this point, however, Winnicott focused on the more familiar psychoanalytic concepts of ego development.

Mother and baby each bring to the nursing situation their own capabilities and needs. The mother brings knowledge, tolerance, and adult judgment. The baby brings absolute dependence, need, and a readiness for hallucinatory gratification. Sights, sounds, smells, and touches experienced with each real feeding teach the baby what he can and cannot conjure up when the real object is not present but real need is exerting itself (1945a/1992, p. 153). Eventually, over substantial periods of time, the mother helps her infant accept and tolerate the limitations of reality, and to enjoy the real satisfactions that such acceptance makes possible:

Real milk is satisfying as compared with imaginary milk, but this is not the point. The point is that fantasy things work by magic: there are no brakes on fantasy, and love and hate cause alarming effects. External reality has brakes on it, and can be studied and known, and, in fact, fantasy is only tolerable at full blast when objective reality is appreciated as well. The subjective has tremendous value but is so alarming and magical that it cannot be enjoyed except as a parallel to the objective. (1945a/1992, p. 153)

In the earliest phase of life, objects act according to magical laws. The object exists when desired, approaches when approached, hurts when hurt, and vanishes when not wanted. Vanishing is a terrifying experience for the infant because it represents

annihilation. To not want—that is, to be gratified after a satisfactory feed—is to evoke annihilation of the object. From this dreamlike world of magic the infant progresses to the real world of planned actions. The change from dreaming to scheming is paralleled by the nature of the changes in the infant's relationship to the object. Initially, following Klein, Winnicott proposed a "ruthless" stage prior to the stage of concern in which the infant expects mother to tolerate its aggressiveness in play. Without this experience of a tolerant caretaker, the infant can show its ruthlessness only in dissociated states. In later life, the ruthlessness can be shown only in states of disintegration marked by abrupt regression to the primitive and magical world of infancy. In short, ruthless relations to objects reappear in psychotic-level psychopathologies.

"THERE'S NO SUCH THING AS A BABY"

"I once risked the remark, 'There is no such thing as a baby'—meaning that if you set out to describe a baby, you will find you are describing a *baby and someone*. A baby cannot exist alone, but is essentially part of a relationship" (Winnicott, 1964a, p. 88; 1969d, p. 253). This instance of Winnicottian hyperbole is a landmark in both object relations theory and in the public presentation of Winnicott's authentically original views. He had learned important lessons from Melanie Klein and from his own pediatric practice. Contrary to orthodox Freudian theory, Winnicott put the focus of child emotional development, not solely on the child, but on the "nursing couple": a child-in-an-adaptation-enhancing-relationship-with-a-mother who provides a "good enough" environment.

"There is no such thing as a baby." I was alarmed to hear myself utter these words and tried to justify myself by pointing out that if you show me a baby you certainly show me also someone caring for the baby, or at least a pram with someone's eyes and ears glued to it. One sees a "nursing couple."

In a quieter way today I would say that before object relationships the state of affairs is this: that the unit is not the individual, the unit is an environment-individual-set-up. By good-enough child care, technique, holding, and general management, the shell becomes gradually taken over and the kernel (which has looked all the time like a human baby to us) can begin to be an individual. (Winnicott, 1952/1992, p. 99)

Winnicott's insistence that babies make psychological sense only in relationship to their environments, specifically the "ordinary devoted mother," was an important corrective to Melanie Klein's often one-sided emphasis on the infant's instincts.

Holding: Primary Maternal Preoccupation of the Ordinary Devoted Mother

Winnicott hypothesized the existence of a special psychological state called "primary maternal preoccupation." Among its characteristics are:

It gradually develops and becomes a state of heightened sensitivity during and especially towards the end of 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. (Winnicott, 1956/1992, p. 302)

Winnicott suggested that this special state is comparable to a psychiatric illness except for the fact of pregnancy. Indeed, the specific comparisons that suggested themselves to Winnicott were dissociation with fugue (i.e., amnesia for personal identity with flight to a new location) and schizoid states (for details, see the clinical taxonomy in Chapter 1). Winnicott argued that only by understanding this illness-like state of the mother and her recovery from it could the earliest relationship between infant and mother be understood. Nevertheless, in typical Winnicottian contrarian fashion, he referred repeatedly to the "ordinary devoted mother" or the "good enough mother" to describe the mother who undergoes this "illness" (Winnicott, 1966c/1987; 1971, p. 12).

The mother's special state provides a specific adaptive context for the unique infantile properties of her newborn to flourish and mature. The mother is "sensitized" to the newborn's state and she can empathically put herself in the infant's place. She "knows" her infant's needs and capabilities as she knows her own. In short, the primary maternal preoccupation results in a close identification of mother with her infant (Winnicott, 1960c/1965a, p. 147).

For their part, infants bring their biological constitution, innate developmental tendencies (conflict-free ego functioning), motility, and drives to the mutuality equation. Mother's heightened empathy permits the kind of silent communications that enable the infant's "innate equipment" to unfold, helps the infant experience free movement for the first time, and encourages the child to take ownership of its body and sensations (personalization). In short, the mother provides a "good enough" adaptation to infantile absolute dependency of need.

... from these silent communications we can go over to the ways in which the mother makes real just what the baby is ready to look for, so that she gives the baby the idea of what it is that the baby is just ready for. The baby says (wordlessly of course): "I just feel like ..." and just then the mother comes along and turns the baby over, or she comes with the feeding apparatus and the baby becomes able to finish the sentence: "... a turn-over, a breast, nipple, milk, etc., etc." We have to say that the baby created the breast, but could not have done so had not the mother come along with the breast just at that moment. The communication to the baby is: "Come at the world creatively, create the world; it is only what you create that has meaning for you. Next comes: "the world is in your control." From this initial *experience of omnipotence* the baby is able to begin to experience frustration and even to arrive one day at the other extreme from omnipotence, that is to say, having a sense of being a mere speck in the universe, in a universe that was there before the baby was conceived of and conceived by two parents who were enjoying each other. (Winnicott, 1968a/1987, pp. 100-01)

Winnicott grouped these various "good enough" maternal caretaking practices under the general, and metaphorical, label of *holding*. In its literal sense, the mother "holds" her infant securely in her arms while feeding, cleaning, and playing with it. This tight and intimate physical closeness provides the initial and most primitive level

of maturational "holding." At a more sophisticated, metaphorical, level, holding embodies a number of interconnected more emotional communications from mother to child.

In describing communication between baby and mother, then, there is this essential dichotomy—the mother can shrink to infantile modes of experience, but the baby cannot blow up to adult sophistication. In this way, the mother may or may not talk to her baby; it doesn't matter, the language is not important. (Winnicott, 1968a/1987, p. 95)

Holding communicates to the infant that it is alive—"I am seen and I exist"—as the child feels mirrored in the mother facial expressions and reactions (Winnicott, 1962c/1965a, p. 61). Inherent in these mirroring experiences are the infant's gradual realization that there *is* another, someone who is *not* me, who reacts to me. A "membrane"—another Winnicottian metaphor—develops between the infant "me" and the infant's experience of the other, "not-me." Personality integration, as we have seen, gets its impetus from these "holding" communications.

Holding and the Unthinkable Anxieties

Perhaps more important, holding provides a safety net for the infant to survive the earliest and most terrifying first fears. Influenced again by Klein, Winnicott described a series of infantile *unthinkable anxieties* or primordial fears that date to the earliest days of life. Unlike Klein, Winnicott saw these "anxieties" as normal developmental phases, not as derivatives of the death instinct. More important, unthinkable anxieties are not necessarily precursors of personality pathology but can become the core of serious psychopathology when mother's holding functions fail. Typically, however, the combination of maternal "holding" and an infant who is constantly on the verge of unthinkable anxiety is the recipe for normal personality integration, personalization, and realization. The unthinkable anxieties are:

- Going to pieces
- Falling forever
- Having no relationship to the body
- Having no orientation
- Complete isolation because of there being no means for communication.

Winnicott added the last item in the list some years after his initial formulation (1962c/1965a, p. 58; and 1968a/1987, p. 99). Maternal holding is the totality of the mother's loving physical and emotional care that, to extend Winnicott's metaphor, prevents the infant from toppling over the abyss of unthinkable anxiety.

Winnicott pointed out the parallel to the analyst's "holding" interpretations in therapy. The words sometimes are less significant than the nonverbal and spontaneous message that the analyst and the patient are both alive and continue to be real. For example, Winnicott related the incident of the patient who dug her nails into the back of his hand during an intense moment in therapy.

My interpretation was: "Ow!" This scarcely involved my intellectual equipment at all, and it was quite useful because it came *immediately* (not after a pause for reflection) and because it meant to the patient that my hand was alive, that it was part of me, and that I was there to be used. Or, shall I say, I can be used if I survive. (Winnicott, 1968a/1987, p. 95)

The medium of "holding" communications, as might be expected from Winnicott's metaphors, tends to be physical care. Rocking, cleaning, mother's breathing and heart beat, the sounds she makes, and the smells she has are all significant messages to the infant. Playing, not games, but the interplay between mother and baby constructs a "virtual space" or common ground between them. It is not physical play space, as in a specific area of the floor or table top, but an interactive "secret space" built from gesture and nod, affection and enjoyment. It is a "no-man's-land that is each man's land, the place where the secret is. . . ." (Winnicott, 1968a/1987, p. 100)

REAL AND FALSE SELVES

Good enough adaptation means, in Winnicott's vocabulary, encouragement and support for the infant's "going on being" (Winnicott, 1956/1992, p. 303). The mother protects the infant from "impingements." Impingements are any experiences that jeopardize "going on being." They can stem either from the external environment or originate in occasional maternal "failures" to provide "good enough" care. Unreliable need satisfaction, prolonged separation from each other, intolerance of infantile neediness and aggression, or an inability to make the infant feel safe are all forms of impingement because they threaten spontaneous and normal developmental progress (Winnicott, 1968a/1987, p. 95). Winnicott's focus here, as always, is on the spontaneous and healthy developments of infancy and those special maternal actions that enhance healthy personality formation. The infant must learn to be real to survive. To do so, the infant must feel safe enough to be spontaneous, secure enough to embrace a self that can sacrifice spontaneity, even die (Winnicott, 1956/1992, p. 304). The good enough mother makes "normally difficult life" tolerable, manageable, masterable:

. . . 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 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. (Winnicott, 1956/1992, pp. 304-05)

Winnicott's concept of the False Self seems to have originated from two sources. First, Winnicott had a keen interest in working therapeutically with severely regressed adult patients who were psychotic or near psychotic. Winnicott saw the dependency needs of the infant re-emerge in an exaggerated form that provided a window on a peculiar sort of personality splitting in his adult schizophrenic and borderline patients. In particular, one patient described to Winnicott how she had felt all her life

that she had not been "real," and felt as though she had been looking for her "True" self (1960c/1965a, p. 142). From the patient's point of view, the first two years of her analysis had been conducted between what she called her "caretaker self" and Winnicott. This caretaker self had sought out treatment, protected the patient during the early phases, gradually handed over its role to Winnicott, and "hovered" nearby to resume caretaking whenever Winnicott "failed" to "hold" the patient safely.

The second origin for Winnicott's concept of the False Self was his experience with apparently cheery children who visited his hospital clinic displaying exuberance and delight in being alive. Nevertheless, these children, by definition, are at the same time *presented for psychological treatment* by their parents, often with maternally described problems of depression, listlessness, anger, and apathy. This marked discrepancy between direct observation and maternal report caught Winnicott's attention:

It took me years to realise that these children were entertaining me as they felt they must also entertain their mothers, to deal with the mother's depressed mood. They dealt with or prevented my depression or what might be boredom in the clinic; while waiting for me they drew lovely coloured pictures or even wrote poems to add to my collection. I have no doubt that I was taken in by many such cases before I eventually realised that the children were ill and were showing me a false self organisation and that at home the mother had to deal with the other side of this, namely the child's inability to keep up counteracting the mother's mood all of the twenty-four hours.

Indeed the mother had to endure the hatred belonging to the child's sense of having been exploited and of having lost identity. (Winnicott, 1969c/1989, pp. 247-48)

Winnicott discovered that some of these "entertaining" children had developed their False Selves not only to "cheer up" their depressed mothers, but also to fend off her hatred of them (1969c/1989, p. 249; 1948d/1996, pp. 91-92). We return to the concept of the mother's unconscious hatred of her child shortly. It is of some benefit at present, however, simply to note that Winnicott links the three concepts of maternal depression, hatred, and the False Self.

Origins of the False Self: The "Not Good Enough" Mother

From clinical observations such as these, Winnicott hypothesized that the primary purpose of the False Self is defense of the True Self. It is a mask that others perceive as real, and, when successfully executed, totally conceals the True Self. The question arises: Against what is the False Self protecting the True Self? Winnicott's answer is "exploitation" and "impingement."

The origins of the False Self are in failures of the mother-infant relationship during the phase prior to the integration of the infant's personality (1960/1965a, p. 145). The "not good enough" mother fails to hold her infant securely and reliably. She may permit external reality to "impinge" on the infant's world before the infant is ready. Or she herself may intrusively impinge on that world in a way that the infant cannot tolerate. Such "errors" of maternal care fail the infant in two ways. First, the "not good enough mother" does not validate or help make real her infant's spontaneous gestures. She does not mirror in her responses her empathic understanding of the infant's needs or wonderment at her infant's successes. In Winnicott's terms,

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. (1960c/1965a, p. 145)

The second failure of the not good enough mother is that she does not help her infant link its spontaneous gestures with observable effects in reality, including her own reactions. Thus the infant is unable to reach the stage of "giving up" omnipotence and hallucination in favor of manipulating the real. Consequently, the infant may not *feel* real. Instead, *illusionary* creating and manipulating are never critically questioned, and therefore never transcended.

In the extreme case, where the maternal failures occur from the very beginning of existence, the infant's survival may be in question. More often, however, the not good enough mother is not "bad enough" to disrupt infant survival totally. Instead, the infant complies with the maternal environment by creating the mask of the false self:

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. (Winnicott, (1960c/1965a, p. 146-47)

Ultimately, the chief defensive efforts of the False Self are directed to protecting the True Self from exploitation, manipulation, and unjust demands. The most "unthinkable" anxiety of all is thus fended off: Annihilation of the True Self.

Levels of Organization of the False Self

Winnicott distinguished five different "levels" of False Self personality organization. They are organized along a spectrum of severity extending from gross maladaptation to ordinary healthy adaptation.

Extremely Maladaptive: Mask

The False Self is organized as "real" and observers see and relate only to the "real" False Self as it takes over relationships in work, love, play, and friendships. The True Self is completely masked. With time, however, the False Self shows signs of failure because life continues to present situations in which a whole person is required.

Moderately Maladaptive: Caretaker

The False Self defends the True Self and even serves as its "protector" or "caretaker." The True Self is dimly acknowledged as a "potential" self and is permitted to have a "secret life." Winnicott's constant search of the healthy silver lining exhibits itself most clearly when he wrote of the moderately pathological False Self that it 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" (1960c/1965a, p. 143).

Minimally Adaptive: Defender

The False Self can serve as a defender against exploitation of the True Self, biding its time until proper conditions for the emergence of the True Self can be found. If safe conditions are not encountered, the False Self may defend the True Self literally to death: suicide. When there is no hope left that the True Self can emerge safely, then the False Self can mobilize the psychological equivalent of a scorched earth policy. The False Self carries out suicide with the paradoxical intention of preventing the annihilation of the True Self by accomplishing the absolute destruction of the entire self. *Good news:* Having successfully executed, as it were, its defensive task, the False Self is needed no longer. *Bad news:* Suicide is the False Self's way of saying, "oops."

Moderately Adaptive: Imitator

A False Self is organized within the personality, but is modeled on caring, productive, and protective people. Although the person feels as though he or she is sometimes "not really real," or continually searching for him- or herself, the False Self comprised of benign identifications can negotiate a very successful life.

Adaptive: Facilitator

The False Self is organized "normally" as ordinary elements of socialization, including polite behavior, personal restraint, false-but-charming modesty, and deliberate control over personal wishes and urges. Without this benign False Self, a kind of socially sophisticated alter ego, the unvarnished True Self would not achieve a place in society as successful or as satisfying.

Table 5.3 summarizes the levels of False Self organization.

The True Self: Aliveness

The True Self is real, spontaneous, and creative. It originates in the "aliveness" of the body tissues and functions, especially the beating of the heart and the regularity of

TABLE 5.3 Winnicott's Levels of False Self Organization

False Self	True Self	Consequence
Extremely Maladaptive: <i>Mask</i>	Completely hidden beneath an utterly compliant False Self.	False Self fails when life demands a whole spontaneous person.
Moderately Maladaptive: <i>Caretaker</i>	Permitted secret life, regarded as potential self.	Preservation of individual in abnormal environments. Minimal spontaneity, aliveness.
Minimally Adaptive: <i>Defender</i>	Waits for safe/desirable conditions to reveal True Self.	Possible suicide if hope for safe conditions is lost; little aliveness.
Moderately Adaptive: <i>Imitator</i>	Identifies with caring or productive objects as models.	Successful life, but without realness, aliveness.
Adaptive: Facilitator	Normal socialization for politeness and self-restraint.	Humility, modesty, social success.

breathing (Winnicott, 1960c/1965a, p. 148). At the beginning, the True Self is linked to the primary process thinking of the unconscious and is therefore not responsive to external reality (see the discussion of primary process thinking in Chapter 3). Forever fond of opposites, Winnicott points out that the True Self acquires its greatest meaning when compared to the False Self. At core, True Self is a synonym for the "experience of aliveness." It is thus initially little more than sensory motor aliveness.

Gradually the True Self grows more complex and develops its own links to reality. At first, reality is understood as a projection of the inner world. Somewhat later, reality is actually "real" in the sense of having an objective, outside the self, existence. Finally, the strengthened True Self can tolerate two kinds of momentary breaks in personal continuity. First, physical trauma such as brief separations from mother or physical illness do not have the devastating effect after the emergence of the True Self that they would have had prior to it. Second, "normal" False Self experiences, such as being taught to say "thank you" when the child hardly feels thankful, are taken in stride as part of ordinary socialization without deforming or threatening the integrity of the True Self. In this sense, everyone develops a normal social mask or False Self which functions to provide superficial compliance in social contexts where conformity is routinely required (Winnicott, 1964d/1986, p. 67). Functioning in this way, the False Self is a social compromise.

An intermediate level of functioning of the False Self that lies between healthy compromise and pathological defense lies between dreaming and reality, the cultural life of the actor. People who develop a compliant self capable of manipulating symbols and language can use their skills to play roles deliberately, entertainingly, and convincingly in the world of drama. The False Self becomes a sublimation of the True Self rather than a defender. However, when the split between the True and False Selves is large, the person is impoverished in the use of symbols, language, and cultural skills.

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. (Winnicott, 1960c/1965a, p. 150)

The greatest danger of the successful False Self is that it will be too successful. By hiding the True Self, the False Self may bury its potentialities so deep that they are no longer accessible, no longer constitute the core of the person's "going on being." That level of "success" means, ironically, that the defense actualizes the very fear—virtual obliteration of the True Self—that it was intended to prevent.

TRANSITIONAL OBJECTS AND TRANSITIONAL PHENOMENA

A *transitional object* in Winnicott's sense is, as its name implies, anything—even a part of the child's own body, such as a fist or thumb—to which the child "relates" with the behavioral/cognitive capabilities it has at that moment (Winnicott, 1959/1989, p. 53). It is, in Winnicott's phrase, the child's "first not-me possession." Early on, the

infant's own tightly balled fist in the mouth is "explored" with tongue and lips in pretty much the same way as the breast or bottle are explored and comprehended. Later in development, external objects—rattles, stuffed toys, and the like—will become transitional objects with which the infant, guided by the sensitive assistance of the attuned mother, establishes a "relationship." Between the two extremes of completely subjective reality of one's self and one's own desires and the completely external reality of the world and its people, there are transitional phenomena, the world of the partly subjective, partly objective transitional object (Winnicott, 1971, p. 2).

At first, when the infant's needs are aroused, it provides its own objects on demand (the fist or thumb in the mouth). Sometimes the infant's crying and other signs of distress or excitement prompt the mother to provide the nipple or bottle. From the child's point of view, each time *desire created satisfaction*. Subjectivity is all there is. Objective reality, things that are "not me," and people who are "not me," simply does not exist. To the infant it appears that the subjective wish is sufficient to construct the gratification, a feeling that can be described in adult language as omnipotence. On some occasions, the infant will "conjure" up an image of what it wants, and because the sensitive mother is attuned and can read her child's signals of curiosity or distress, she "magically" seems to provide the exact object desired: a teddy bear, rattle, blanket, or the like. Again the infant has conjured an object, and it seemingly has materialized—a kind of "hallucinatory omnipotence." Winnicott calls this the "moment of illusion."

The mother, at the beginning, by an almost 100-per-cent adaptation affords the infant the opportunity for the *illusion* that her breast is part of the infant. It is, as it were, under the baby's magical control. The same can be said in terms of infant care in general, in the quiet times between excitements. Omnipotence is nearly a fact of experience. The mother's eventual task is gradually to disillusion the infant, but she has no hope of success unless at first she has been able to give sufficient opportunity for the illusion.

In another language, the breast is created by the infant over and over again out of the infant's capacity to love or (one can say) out of need. A subjective phenomenon develops in the baby, which we call the mother's breast. The mother places the actual breast just where the infant is ready to create, and at the right moment. (Winnicott, 1971, pp. 12-13)

Besides the breast, other "objects," such as a teddy bear or a favorite blanket, are dimly recognized by the infant as not belonging to the infant's body ("not me"). However, they are not necessarily fully comprehended as belonging to the outside world or to another person either. Such objects are *transitional* in the senses of:

- PLACE: bridging inner and outer
- AGENCY: bridging hallucinatory omnipotence and dependency on a real external agent
- SEPARATENESS: bridging not-me and me.

(Derived from: Winnicott, 1971, p. 2)

What is important for Winnicott is not the object itself, but the process of transition between subjective hallucination and objective reality-testing. These objects are not completely magical nor are they completely real. They are transitional.

I have introduced the terms "transitional object" and "transitional phenomena" for designation of the intermediate area of experience, between the thumb and the teddy bear, between the oral erotism [sic] and true object relationship, between primary creative activity and projection of what has already been introjected, between primary unawareness of indebtedness and the acknowledgement of indebtedness (Say: ta! [i.e., "thanks"])). (Winnicott, 1951/1992, p. 230)

Thus, for Winnicott, transitional objects and phenomena are fundamentally intermediate between reality and illusion, landmarks on the road to full acceptance of the real. However, there are "rules" of ownership over the transitional object that the infant exercises with care:

- The infant assumes rights over the object, and we agree to this assumption. Nevertheless, some abrogation of omnipotence is a feature from the start.
- The object is affectionately cuddled as well as excitedly loved and mutilated.
- It must never change, unless changed by the infant.
- It must survive instinctual loving, and also hating, and, if it be a feature, pure aggression.
- Yet it must seem to the infant to give warmth, or to move, or to have texture, or to do something that seems to show it has vitality or reality of its own.
- It comes from without from our point of view, but not so from the point of view of the baby. Neither does it come from within; it is not an hallucination.
- Its fate is to be gradually allowed to be decathected, so that in the course of years it becomes not so much forgotten as relegated to limbo. By this I mean that in health the transitional object does not "go inside" nor does the feeling about it necessarily undergo repression. It is not forgotten and it is not mourned. It loses meaning. . . .

(Winnicott, 1951/1992, p. 233)

Winnicott assumed that at least for some infants in some circumstances, the transitional object served as a symbol for a part object. Thus a piece of cherished blanket symbolizes the nurturing breast for some infants; for others it may symbolize feces (1951/1992, p. 236). Yet the fundamental purpose remains the same: Transitional objects are the infant's first "tools" in negotiating the gap between the illusion of magical creation of desired objects and the disillusion that such objects have their own, willful, existence.

With time, of course, the infant learns to distinguish between "me" and "not-me," between "inner" and "outer," and between illusion and reality because at least some of the time its needs will not be instantly gratified no matter how intense the wish. Reality in the form of external frustration and obstacles makes itself known. And, of

course, the mother herself will become a real "object" with whom the infant establishes a mutual relationship. Out of this relationship will come important psychological understandings about trust in self, trust in others, and how to "relate" to people.

Transitional phenomena are not restricted to infancy. Even as adults the task of relating inner to outer reality continues to make its demands felt. Is there anyone, for example, who does not have photographs of loved ones in his or her wallet? How many of us treasure some "keepsake" possession given us by a distant loved one? Lock of hair? Special letter or poem? At the other extreme, consider the sports fans who will pay huge sums of money to own a sweaty jersey worn by Refrigerator Perry or a golf club once used by John F. Kennedy. Are these transitional objects or fetishes? Winnicott left the issue open.

SEVERE PSYCHOPATHOLOGY AND FAILURES OF ADAPTATION

In what may prove to be an unfortunate extension of his ideas to very severe psychiatric disorders, Winnicott (1966b/1996; 1967/1996), late in his career, extended his model of maternal holding and infantile adaptation to childhood autism and schizophrenia. Winnicott hypothesized that these catastrophic disorders of childhood were failures in the adaptive context provided by "not good enough" mothering. Following the general outlines of a theory advanced by Bruno Bettelheim (1967) in his well-known book, *The Empty Fortress*, Winnicott insisted that the psychotic emotional and intellectual manifestations of autism and schizophrenia were not evidence of a *disease* in the medical sense (Winnicott, 1969b/1989, p. 246n). Bettelheim's psychological formulation and claims of treatment efficacy were themselves controversial in their time and have grown increasingly suspect (Sutton, 1995, pp. 10, 304, and especially 424-27). In his own description of these disorders, Winnicott did nothing to make a purely psychological model less controversial:

The illness is a disturbance of emotional development and a disturbance that reaches back so far that in some respects at least the child is defective intellectually. In some respects the child may show evidence of brilliance.

I am hoping that what follows may strengthen the argument that the problem in autism is fundamentally one of emotional development and that autism is not a disease. It might be asked, what did I call these cases before the word autism turned up? The answer is that I thought of these cases, and I still think of them, under the heading "infant or childhood schizophrenia." (Winnicott, 1966b/1996, p. 200)

Winnicott here condenses the two syndromes of schizophrenia and autism into one family of adaptive failures. By itself, this one theoretical maneuver puts Winnicott at odds with contemporary thinking about these disorders (e.g., American Psychiatric Association, 1994, pp. 75, 77, 273-85). Beyond the classification issues, however, Winnicott's hypothesized etiology for these disorders emphasizes failures in emotional attachment at the cost of dismissing biological causes. Most contemporary thinkers regard childhood-onset schizophrenia and childhood autism as neurological, probably neurochemical, disorders of the brain linked to a modest degree of genetic

predisposition (e.g., Andreasen, 1984; Andreasen and Munich, 1995; Heinrichs, 1993; Torrey, Bowler, Taylor, and Gottesman, 1994).

By contrast, Winnicott argued that the essential feature of these disorders:

Is the *mother's* (or substitute mother's) *capacity to adapt to the infant's needs through her healthy ability to identify with the baby* (without, of course, losing her own identity). With such a capacity she can, for instance, hold her baby, and without it she cannot hold her baby except in a way that disturbs the baby's personal living processes.

It seems necessary to add to this the concept of the mother's *unconscious* (repressed) hate of the child. Parents naturally love and hate their babies, in varying degrees. This does not do damage. At all ages, and in earliest infancy especially, the effect of the repressed death wish towards the baby is harmful, and it is beyond the baby's capacity to deal with this. (Winnicott, 1967/1996, p. 222; emphases in original)

What is significant in Winnicott's formulation is his reference to the mother's repressed aggression toward her baby in the context of the mother's depression. This unusual link between maternal depression-aggression and the infant's attempts to survive reappears in Winnicott's final theoretical formulations. As we shall see in a subsequent "Personal Sources" section, coping with maternal depression was one of Winnicott's own early challenges.

"WASTELAND OF DESTROYED REALITY"

Near the end of his life, Winnicott turned his attention, once again, toward the paradoxical aspects of living and dying. The concepts of survival, creation, and annihilation had renewed fascination for the aging pediatrician. Always the master of puns and paradoxes, Winnicott now grew increasingly philosophical. His thinking became more abstract and drawn toward the ontological implications of psychoanalytic concepts. In this frame of mind, Winnicott introduced a distinction between *using* and *relating* to an object. The distinction embodied his last concerns in a formulation that elevated psychological paradox into metaphysical existentialism. The theme of survival was placed squarely at the center of the circle of creation, destruction, and recreation—the universal cycle of birth, death, and renewal.

Winnicott's Jungian Dream

While working on a review of Carl Jung's (1961) autobiography, *Memories, Dreams, Reflections*, Winnicott had a dream about a deep layer of destructiveness in human nature that he could master only in the most paradoxical way:

The dream can be given in its three parts:

- There was absolute destruction, and I was part of the world and of all people, and therefore I was being destroyed. . . .
- Then there was absolute destruction, and I was the destructive agent. Here then was a problem for the ego, how to integrate these two aspects of destruction?
- Part three now appeared and *in the dream* I awakened. As I awakened I knew I had dreamt both (1) and (2). I had therefore solved the problem, by using the

difference between the waking and sleeping states. Here was I awake, in the dream, and I knew I had dreamt of being destroyed and of being the destroying agent. (Winnicott, 1963b/1989, pp. 228-29; emphases in original)

During awakening, Winnicott was aware of a "splitting" headache. He even envisioned himself with his head divided showing a "black gap" between the two halves. While trying to reach full wakefulness, Winnicott lay pondering the dream and its meaning. His interpretation was that, in the dream, he had been split into three essential selves, corresponding to the three parts of the dream: a sadistic *destroyer*; a masochistic *victim* of destruction, and a *survivor* of destruction. But self number three was aware of being the agent of destruction as well as the object of destruction—and thus had survived. Without "I(3)," as Winnicott called his third self, he realized that he would be doomed to remain split, "solving the problem alternately in sadism and masochism, using object-relating, that is, relating to objectively perceived objects" (Winnicott, 1963b/1989, p. 229).

Having worked on the review of Jung's autobiography, Winnicott realized that he was "dreaming a dream for Jung and for some of my patients, as well as for myself" (1963b/1989, p. 229). Jung's autobiography, it should be mentioned in passing, contains numerous accounts of Jung's mystical, sometimes apparently psychotic, always magical experiences and dreams from which he drew many of the concepts of his theory (see Chapter 7 for a full account of the autobiography). One of Winnicott's further associations to his own dream was that he had the impression from reading about Jung's childhood that Jung was unaware of his own destructive impulses. Winnicott hypothesized that Jung's blind spot was related to having been cared for by a depressed mother. Thus, again, the theme of destructive but paradoxically creative aggression is linked by Winnicott to a child's attempt to cope with its mother's depression and unconscious aggressiveness.

In a letter to a friend, Winnicott provided the simplest statement of the profound insight he achieved in the dream: "... the individual child finds total destruction does not mean total destruction" (1963b/1989, p. 230).

The Cycle of Aliveness: Using an Object

Winnicott's formulation of transitional objects and phenomena already had laid the foundations for the recognition of the significance of paradox in object relations:

I should like to put in a reminder here that the essential feature in the concept of transitional objects and phenomena ... is *the paradox, and the acceptance of the paradox*: the baby creates the object, but the object was there waiting to be created and to become a cathected object. I tried to draw attention to this aspect of transitional phenomena by claiming that in the rules of the game we all know that we will never challenge the baby to elicit an answer to the question: did you create that or did you find it? (Winnicott, 1968b/1989, p. 221)

What Winnicott had accomplished in formulating the concept of transitional phenomena was to diffuse the usual psychoanalytic focus. Instead of the traditional understanding of the external world as interesting only to the degree that it is a projection of the internal world, Winnicott studied the external world on its own terms.

Transitional phenomena are the bridge between worlds. To exist at all, they require an interaction between subjective and objective reality. Transitional objects are paradoxically both projections and discoveries. Part illusion, part perception, transitional phenomena belong to the middle ground between unreal and real. They are projections sent into the objective world by an infant who creates them in the subjective world; but projections are, by definition, *projected onto something*. That suitable *something* is always also an *accessible something*. It is a *something* that happens to be available at exactly the moment the baby is ready to create. In this very metaphysical sense, then, the baby repeatedly creates and recreates its image and experience of the breast as love object (Winnicott, 1951/1992, p. 238).

In line with his insight of his "three-self" dream, Winnicott now argued that a baby progresses from *relating* to *using* the love object. The transition between relating and using presupposes destroying the object in fantasy. The specific sequence follows this logic: In the first phase, *relating to the object* requires that the infant advance from magical understanding of the object's existence as a projection under omnipotent control to realistic comprehension of the object as a real, independent, objectively existing entity. Mother becomes a person. At that point, following Melanie Klein's hypotheses, the baby's innate destructiveness meets an obstacle it had never before encountered. Real objects *survive* fantasies of destruction.

Indeed, the most significant developmental advance in distinguishing between fantasy and reality comes from this very stubborn refusal of real objects to be obliterated by wishing. "Aha!" says the infant, "total destruction is not total destruction" for objects that *really* exist continue to exist. The attempt at destruction—and most important, the *failure* of the attempt—is the trigger for the infant to place the object outside subjective reality and squarely into the world (Winnicott, 1968b/1989, p. 223). Winnicott summarized the paradoxical logic of his hypothesis in this way:

This is a position that can be arrived at by the individual in early stages of emotional growth only through the actual survival of cathected objects that are at the same time in process of becoming destroyed because real, becoming real because destroyed. . . . (1968b/1989, p. 223)

[And]

There is no anger in the destruction of the object to which I am referring, though there could be said to be joy at the object's survival. From this moment, or arising out of this phase, the object *is in fantasy always* being destroyed. This quality of "always being destroyed" makes the reality of the surviving object felt as such, strengthens the feeling tone, and contributes to object-constancy. The object can now be used. (1968b/1989, p. 226; emphasis in original)

A main effect of Winnicott's hypothesis was to shift the emphasis in psychoanalysis away from the theory that the infant's understanding of external reality is based primarily on its own projections. In accord with his long-standing emphasis on the facilitating environment, Winnicott's "use of an object" concept split the focus equally between internal and external reality.

But what, precisely, does it mean to say that the infant progresses from relating to *using* the object? Winnicott argued that the infant's realization that the object survives its attacks—*without retaliating*—enables the baby not only to believe in its external existence, but also to trust the object. An object that survives the most

intense destruction the infant can muster and that does not strike back is a "good enough" mother whose reliability and trustworthiness are usable—helpful—in learning how to cope with normally difficult life.

Reactions to the Hypotheses

When Winnicott first presented these ideas—the culminating but paradoxical achievements of a long career—to a meeting of the New York Psychoanalytic Society, they were not welcomed with enthusiasm. For one thing, Winnicott was understood to be equating object *relating* to subjective reality and object *using* to external reality. In Winnicott's scheme, the ability to use the object in the external world was the more sophisticated phase of emotional development. Thus some psychoanalysts perceived Winnicott's concepts as diminishing the importance of the internal world.

Even more resistance to Winnicott's ideas were couched in clinical terms. Winnicott's hypothesis implied that only through the patient's discovery that aggression toward the analyst does not destroy the analyst—and indeed is tolerated by the analyst without retaliation—can the patient "use" the therapist therapeutically. If the patient does not achieve this level of emotional development, the treatment is stalled at a subjective level of "self-analysis." The patient does not construct or use the analyst as a real person. Put another way, the analyst would be a projection of the self (Winnicott, 1968b/1989, p. 224). Thus Winnicott implied that psychoanalytic treatment was not exclusively a matter of interpretation. "Holding" and "good enough" therapeutic parenting that enable the patient to "use" the analyst as a collaborator in the search for maturity were at least equally important. Implications such as these were given a hostile reception by the New York analytic community in 1968, and Winnicott, who was already in declining health, suffered a heart attack the day after his presentation that prevented his return to London for more than a month.

PERSONAL SOURCES FROM WINNICOTT'S CHILDHOOD

If ever a man were born to be a mother, it was Donald Woods Winnicott. His near magical talent for communicating with children became legendary (cf. C. Winnicott, 1983/1991, p. 184). A particularly revealing and charming story is told, for example, of Winnicott's return visit to a Danish family after a period of some years. The children were eager to see him again because they remembered happily how he had played with them. They were delighted to talk with this Englishman who spoke Danish so well. But the children's father tried to forestall disappointment by telling them that Dr. Winnicott did not speak Danish. He failed to persuade them even though he was correct (anecdote reported in Goldman, 1993, p. 57). Language was no barrier in the children's memory of the man.

The majority of Winnicott's biographers agree that he had a strong identification with his mother and an empathic bond with all mothers (especially C. Winnicott, 1978, 1989; see also Goldman, 1993; pp. 47ff.; Jacobs, 1995; Kahr, 1996; Phillips, 1988). It is heartening, too, that Winnicott's childhood has been described by his second

wife Clare as "too good to be true" in the particular sense that Donald was loved, knew he was loved, and thought of himself as lovable (1989, p. 9). He grew up fundamentally happy and secure. To judge from the substance of the theory he left behind, his vision of humanity was certainly individualized by his experiences—even, necessarily, idiosyncratic ones—but it does not appear to have been driven by psychopathology.

Taking Charge: Doctors, Darwin, and Death

If anything at all can be said to have driven Donald Winnicott's personality development it was his profound need to be actively and exclusively in charge of his life. For example, when he broke his collar bone at sports, he came to the realization that he would have to "depend" on doctors for the rest of his life everytime he "damaged" himself or became ill (C. Winnicott, 1989, p. 10). Enforced dependence on anyone meant vulnerability to Winnicott. Illness and "damage" were loathsome, if unavoidable, paths on life's road that Winnicott had already decided to travel only on his own terms. He would, quite directly, pursue an independent route. By becoming a physician, he would take active control over, and responsibility for, the vulnerabilities of his life. It is not difficult to see that the young Winnicott, as he observed in so many children throughout his career, was making first contact with the discomforting meanings of his own mortality. Characteristically, his response was to take charge.

In a similar vein, his encounter during his school years with the writing of Charles Darwin set the pattern of Winnicott's intellectual and philosophical life. Painting on a cosmically vast canvas, Darwin made life itself seem humanly comprehensible. To Winnicott, Darwin's ideas meant living things could be understood "scientifically." Gradually he envisioned the need for a psychological Darwin whose work would advance a unified understanding of human behavior in the same "scientific" way. Winnicott ultimately found his psychological Darwin in Sigmund Freud (Winnicott, 1945b/1996, p. 7). Such extraordinary yearnings for the independence of spirit to master life's vulnerabilities had the effect of elevating doctors, Darwin, and death to the ranks of the high rollers at Winnicott's table.

Donald Winnicott was also a playful man and remained so until his death. His wife Clare Winnicott (1983/1991) recalled that she and her husband rarely sat in chairs at home, preferring to spread out their books and papers on the floor for a good read or simply to watch television. And together they often played the squiggle game. Clare remembered fondly how Donald loved to ride his bicycle with his feet up on the handle bars, tearing exuberantly down Haverstock Hill. He rode like that until very late in life, when a policeman stopped him to say, "Fancy an old man like you setting an example to everybody" (1983/1991, p. 192). Driving his car was an opportunity for similar playfulness. He drove standing up, a walking stick propping the accelerator forward, while he stuck his head up through the open roof. "He was the most spontaneous thing that ever lived" (C. Winnicott, 1983/1991, p. 193).

Multiple Mothers

Donald was born on April 9, 1896, in Plymouth, England, the youngest and only male of three children born to John Frederick Winnicott and Elizabeth Martha Woods. His

sisters were already five and six years of age when Donald joined the Winnicott family, self-described as "Wesleyan Methodists" (Phillips, 1988, p. 23). Clare Winnicott (1983/1991, p. 184) pointed out that the Methodist tradition is one of strong independence, self-reliance and nonconformity, characteristics that certainly describe Winnicott himself.

Donald recalled as an adult that: "... in a sense I was an only child with multiple mothers and with a father extremely preoccupied in my younger years with town as well as business matters" (quoted in C. Winnicott, 1989, p. 8). Clare Winnicott recalled that Donald had thought he did not have enough contact with his own father: "So he says, 'I was left too much to all my mothers. Thank goodness I was sent away at thirteen!'" (1983/1991, p. 185). In fact, the members of the Winnicottian household in which Donald grew up were almost exclusively female. Two older sisters, his mother, a nanny, sometimes a governess for his sisters Violet and Kathleen, his Aunt Delia and another aunt, a cook and several parlor maids populated the Winnicott household, and all "doted" on Donald (Kahr, 1996, p. 5). As a child, Donald especially loved to spend time in the kitchen with the cook. His wife Clare later reported that this remained an interest though his adult life. The one place you were certain to find Dr. Winnicott was the kitchen (C. Winnicott, 1983/1991). All the Winnicott females loved children and all of them, well into their elderly years, maintained the knack of playing and talking with youngsters (C. Winnicott, 1983/1991).

This unique constellation of a little boy fully enveloped by mothers and virtually deprived of a father seems to have left an indelible impression on Winnicott's psychological development, resulting in a powerful female identification. First of all, because young Donald received so much affection from so many women with whom he interacted in a reliable manner, he felt protected, safe, and secure, and this emotional stability provided him with a solid foundation for a sturdy, productive, and creative adult life. Secondly, the preponderance of women in Winnicott's childhood stimulated an extreme fascination with the inner world of the female. . . . (Kahr, 1996, p. 6)

As Winnicott's biographer concludes, life contrived to have him confront the nature of femaleness at nearly every turn down the path of childhood (Kahr, 1996, p. 6). One less positive legacy of a childhood spent with so many women and so little paternal attention was a high pitched and squeaky voice that Donald himself detested. Years later when he did his radio broadcasts for the British Broadcasting Corporation, he received a considerable number of letters addressed to "Mrs." Winnicott (Kahr, 1996, p. 7).

Donald's Mother: Elizabeth Woods

For all his focus on mothers, Donald's mother is a biographically indistinct figure about whom few details are known. There is some evidence that Elizabeth Woods struggled with episodes of depression throughout her life and that Donald's very absent father unconsciously assigned his son to care for and cheer up his mother (Kahr, 1996, p. 10). Clare Winnicott quoted her husband's observation that "... it is probably true that in the early years [my father] left me too much to all my mothers. Things never quite righted themselves" (C. Winnicott, 1989, p. 8; see also C. Winnicott, 1978, p. 24). At the age of 67, Winnicott wrote a poem about his mother entitled "The

Tree," which he sent to his brother-in-law with a note acknowledging the hurt he felt in composing it:

Mother below is weeping
 weeping
 weeping
 Thus I knew her
 Once, stretched out in her lap
 As now on dead tree
 I learned to make her smile
 to stem her tears
 to undo her guilt
 to cure her inward death
 To enliven her was my living.

(quoted in Phillips, 1988, p. 29)

The tree referred to in the title was the special place to which the young Donald retreated to do his homework. Phillips (1988) points out that there is religious symbolism in Winnicott's choice of metaphor:

In the poem Winnicott clearly identifies himself with Christ, and the Tree of the title is the Cross. . . . The chilling image of himself 'stretched out on her lap/As now on dead tree,' by omitting the definite article suggests that once it is dead it is no tree in particular, as anonymous as dead wood. (Phillips, 1988, pp. 29-30)

Is it worth mentioning that Donald *Woods* Winnicott's middle name is his mother's maiden name? It is probably more worthwhile to point out that his poetry alludes to the role that the young Winnicott played in combating his mother's "deadness." The poem poignantly also expresses themes that occupied Winnicott professionally for his entire career:

- feeling fully alive versus feeling dead numbness,
- maternal depression experienced by the child as aggression,
- the needs of the child for maternal holding,
- the protective role of a superficially compliant cheerful False Self, and
- the False Self as caretaker.

Winnicott understood that at the beginning and at the end of his life that he had made, ". . . a living out of keeping his mother alive" (Phillips, 1988, p. 30).

Donald's Father: Sir John Frederick Winnicott

John Frederick Winnicott was a successful merchant, specializing in women's corsetry. He was a religious man with a simple but strong faith who attended church

regularly and apparently viewed himself as the patriarch of the household. As the only male child, young Donald had the privilege of walking home from church as his father's solitary companion. John Winnicott was twice elected mayor of the town of Plymouth and was knighted in 1924 (Phillips, 1988, p. 23). "Sir Frederick," as he became known, was active in town politics and the business community, and even became Manager of the Plymouth Hospital and Chairman of the Plymouth Chamber of Commerce. Despite these accomplishments, Frederick Winnicott felt insecure throughout his adult life about his lack of a "proper" education (Phillips, 1988, p. 23). His aspirations to become a member of Parliament foundered on lifelong "learning difficulties," which John Frederick believed had robbed him of the confidence to enter the world of politics outside his local community (Kahr, 1996, p. 4).

For all of his success in local business and politics, John Frederick was a distant parental figure and inept father to his son. His relationship with Donald was formal rather than intimate, and sometimes surprisingly authoritarian. Indeed, Frederick Winnicott could be so insensitive to his son's needs that Donald risked the humiliation of his father's teasing for even minor infractions of Winnicottian decorum. On one occasion, 12-year-old Donald used the word *drat* as an expletive during the noonday meal:

... my father looked pained as only he could look, blamed my mother for not seeing to it that I had decent friends, and from that moment he prepared himself to send me away to boarding school, which he did when I was thirteen. (quoted in C. Winnicott, 1989, p. 8)

Perhaps it was characteristic for Winnicott to "detoxify" the recollection into a more benign memory than the reality on which it was based, but Winnicott recalled in his autobiography that in fact his father fundamentally had been correct. The boy who was his closest friend in school was "no good," and left to their own devices, Winnicott envisioned that they would have gotten into trouble. The deeper meaning of the incident—abandonment by his father, or at the very least, banishment and punishment—did not altogether escape Winnicott's Klein-tutored attention. "So my father was there to kill and be killed, but it is probably true that in the early years he left me too much to all my mothers" (quoted in C. Winnicott, 1989, p. 8).

There is some indication that the nature of John Frederick's teasing was linked to issues of Donald's masculinity or sexuality. When Donald was only three, he ascended the grassy slope in the garden armed with his child-sized croquet mallet prepared to exact revenge and make a piece of personal family history. In the tall grass, he bashed flat the nose of a wax doll called "Rosie" that belonged to his sisters. Rosie was a particular source of irritation to young Donald because his father often teased him with the doll by parodying a popular song of the day in a voice intended to taunt:

Rosie said to Donald
I love you
Donald said to Rosie
I don't believe you do.

(quoted in C. Winnicott, 1989, p. 7)

Winnicott (1989, p. 7) says that he "knew the doll had to be altered for the worse, and much of my life has been founded on the undoubted fact that I actually *did* this deed, not merely wish it and planned it." Ironically, his father relieved some of his son's guilt by heating the wax of the doll's head with a series of matches and remolding it into a more or less recognizable face.

This early demonstration of the restitutive and reparative act certainly made an impression on me, and perhaps made me able to accept the fact that I myself, dear innocent child, had actually become violent directly with a doll, but indirectly with my good-tempered father who was just then entering my conscious life. (Winnicott, quoted in C. Winnicott, 1989, p. 8)

It is a subtle autobiographical conceit, but Winnicott clearly and defensively presents the memory of his father as an admirable, even tempered, helpful man for whom he felt only admiration and love. Yet it was the father who provoked humiliation by repeated teasing of his son.

Implications of Winnicott's Childhood

At least three inferences can be drawn from the sample of episodes we have reviewed from the early life of D. W. Winnicott. First, compared to most of the theorists we examine in this book, Winnicott had a happy, secure, healthy childhood in a warm and loving family. For this reason, Winnicott's vision of personality development emphasizes spontaneous collaboration between children and their parents rather than the conflicts that are also inevitably enacted between them. The most frequently occurring personal theme among the theorists in this book (see Chapter 18) is the individual theorist's memory of having been an unwanted child. Winnicott is the only theorist for whom it appears virtually certain that this theme was irrelevant—both in his recollection of childhood and in the reality of his family life. There is a strong temptation to observe that one of the healthiest theories has sprung from the healthiest personal sources.

Second, Winnicott's freedom from childhood insecurity was not immunity from other forms of maternal rejection. Although the definitive biography has yet to be written, the existing body of life history data make it clear that Winnicott's sensitivity to failures in maternal "holding" stemmed from his own experiences trying to vitalize an emotionally numbed and depressed mother. His wish to "be alive" when he died, as we saw in the opening of this chapter, can also be understood as the desire of the man who described the caretaking False Self to not be depressed, to not be merely socially compliant, to not be inauthentic.

Third, Winnicott's theory mentions the contributions of fathers to the development of their children—but just barely. Fathers are not in the Winnicottian spotlight just as Sir Frederick was not in his son's daily life. Winnicott's affinity for and empathy with mothers, his tight focus on mothering, rather than parenting, and his own impressive talents "mothering" and "holding" his patients clearly had their origins in his family traditions of interest in children and in his personal experiences with "multiple mothers." With all due respect, Winnicott must share with Anna Freud, each for unique personal and historical reasons, the title of *mother of object relations theory*. He would be pleased.

A Final Word on Winnicott

Imagine a deserted island after civilization has been destroyed by nuclear holocaust. The island is populated by children who will reestablish human society. Half of the children are prototypical Kleinian and half of them are Winnicottian. Which group, do you suppose, could have inspired William Golding's novel *Lord of the Flies*?

HEINZ KOHUT

BEYOND THE EGO: PSYCHOANALYTIC SELF-THEORY

In many ways, Heinz Kohut's work with patients whose central disturbance involved feelings of emptiness and depression is a therapeutic extension of Margaret Mahler's observations of the roots of individuality. Kohut found the need to extend psychoanalytic theory beyond the ego concept to understand a patient's narcissistic vulnerability in terms of the patient's inadequately formed or damaged sense of self. Such "narcissistically disturbed" individuals seemed not to be suffering from castration anxiety or from conflicted id strivings in the classical sense; they seemed to be fixated at a stage in development where *fear of the loss of the love object prevails* (Kohut, 1971, p. 20).

In the psychoanalytic relationship, such patients form a unique kind of transference to the analyst. An *idealizing transference* develops in some patients who behave toward their therapists as though they were the all-good, all-powerful parent who is still part of the self. Such patients are projecting onto their therapist their idealized images of the "good love object," as though they were still searching and yearning for fusion with it. The obvious conclusion is that such patients suffered severe trauma in that stage of early development when the love object had not yet been entirely distinguished from self:

Persons who have suffered such traumas are (as adolescents and adults) forever attempting to achieve a union with the idealized object, since, in view of their specific structural defect (the insufficient idealization of their superego), their narcissistic equilibrium is safeguarded only through the interest, the responses, and the approval of present-day (i.e., currently active) replicas of the traumatically lost self-object. (Kohut, 1971, p. 55)

Idealizing transferences may occur in a variety of forms, ranging from most archaic and primitive to most mature, depending on the point in development at which narcissistic injury took place. The key point is that such a narcissistically injured person was unable to form internalized capacities for self-control, for self-judgment, and for the maintenance of self-esteem as an independent entity.

A second kind of narcissistically disturbed patient forms a different kind of *mirroring transference* relationship with the analyst. In this form, the patient is regressing to an even earlier stage of development during which, in Mahler's terms, *absolute narcissism* prevails.

The mirror transference . . . constitute[s] the therapeutic revival of that aspect of a developmental phase (roughly corresponding to the condition which Freud referred to as the "purified pleasure ego") in which the child attempts to save the originally all-embracing narcissism by concentrating perfection and power upon the self—here called the grandiose self—and by turning away disdainfully from an outside to which all imperfections have been assigned. (Kohut, 1971, p. 106)

In the mirror transference, the roots of pathology go further back in development to the period before any recognition of the external love object (mother) was formed. The grandiose self is formed by internalizing "all good" and externalizing "all bad" experiences. Good (pleasure) is part of me; bad (pain) belongs out there. This process of assimilating "good" and expelling "bad" is thus a form of splitting in its most fundamental and autistic form.

In the *idealizing transference*, the experience of the mother's aid in satisfying tension needs revolved around the mechanism: "You are perfect, but I am part of you" (Kohut, 1971, p. 27). By contrast, the more archaic *mirror transference* involves the mechanism: "I am perfect" in order to avoid any experience of "the bad" as part of self. In the idealizing transference, the therapist becomes the perfected mother-self image; in the mirroring transference, the therapist functions as a reflector of the archaic self-perfection of the patient. From the patient's viewpoint in a mirroring transference, the therapist is a looking glass in which can be seen displayed the patient's own grandiose, exhibitionistic self.

Origins of the Self

The idealizing and mirroring transference relationships that emerged in psychoanalysis with narcissistically wounded patients served as an important clue to the processes of development. Kohut began to understand that such patients used the therapist as a *Selfobject* rather than seeing the therapist as an independent human being.

Selfobjects are objects [people] which we experience as part of our self; the expected control over them is therefore closer to the concept of the control which a grown-up expects to have over his own body and mind than to the concept of control which he expects to have over others. (Kohut & Wolff, 1978, p. 414)

Like the mirroring and idealizing transferences observed in the treatment of patients with wounded selves, Kohut envisioned normal development as a process of interaction between the growing infant and his or her mirroring and idealizing Self-objects. The mother serves as a *mirroring Selfobject* when she is able to confirm and admire the child's sense of strength, health, greatness, and specialness. The key ingredient, of course, is the mother's capacity to be attuned emphatically to her child's needs for such personal confirmation and admiration.

Mother also serves as an *idealizing Selfobject* somewhat later in development when she encourages and permits the child to merge with her own strength and calmness as a powerful and caring adult. From the child's point of view, the idealizing Selfobject is a model of perfection, power, and soothingness who can be experienced in part as a component of self.

Unlike the classical psychoanalytic model, Kohut's theory of development pictures the mother's relationship with her child not in terms of drive satisfactions but in terms of emphatic, warm, loving responsiveness to the whole child. As a consequence, the child will experience self as a joyful, competent and valuable person, or as a rejected, depleted, empty self. When the Selfobject-child relationship is seriously deficient, as with a latently psychotic mother, the child is as unable to survive psychologically in a loveless relationship as he or she would be unable physically to survive in an oxygenless environment. Human warmth, responsiveness, and empathy are the oxygen, the crucial survival elements in the development of a self that is neither grandiosely isolated from reality nor delusionally idealizing of magical love objects (Kohut, 1977, pp. 75-76).

The essence of the healthy . . . [parental relationship] for the growing self of the child is a mature, cohesive parental self that is in tune with the changing needs of the child. It can, with a glow of shared joy, mirror the child's grandiose display one minute, yet, perhaps a minute later, should the child become anxious and overstimulated by its exhibitionism, it will curb the display by adopting a realistic attitude *vis-à-vis* the child's limitations. Such optimal frustrations of the child's need to be mirrored and to merge into an idealized selfobject, hand in hand with optimal gratifications, generate the appropriate growth-facilitating matrix for the self. (Kohut & Wolff, 1978, p. 417)

Structure of the Bipolar Nuclear Self

Kohut hypothesizes that an adequate relationship with a healthy Selfobject results in the formation of a bipolar self that has three components:

1. *Nuclear Ambitions*, which are the child's learned strivings for power and success *mirrored* admiringly by the Selfobject;
2. *Nuclear Ideals*, which are the idealized goals and images derived from the child's recognition of the satisfying and soothing power *modeled* by the Selfobject; and
3. *Basic Talents and Skills*, which lie metaphorically between the two poles of ambitions and ideals and which form a kind of metaphorical "tension arc" of psychological activity as the person is "driven" by ambitions and "led" by ideals in the pursuit of life goals using what talent and skills he or she possesses. (Kohut, 1977, p. 188)

The nuclear ambitions are formed early in life, at or around the second or third year, whereas the nuclear ideals are incorporated into the self as a second pole around the ages of four or five years (Kohut, 1977, p. 179).

Kohut thus envisions the nuclear self as a bipolar entity, with the ambitions and ideals anchoring opposite poles. The central process in the formation of these two poles, as we have seen, is the relationship with empathic Selfobjects. The nuclear self, however, is not simply a direct copy of the Selfobjects. It is an assimilation of some aspects of their personality characteristics, but the main features of the Selfobject are depersonalized and generalized in a process Kohut calls "transmuting internalization."

Transmuting internalization is a kind of psychological digestion by which the usable and good features of the Selfobject are incorporated into the child's self in a pattern that is unique to that child. Mild frustrations and failures in empathy by the Selfobjects encourage the child to see them as "only human." Such occasional failures in empathy on the part of the Selfobjects permit the child to build his or her own self-structures without the need to incorporate the total personality of others.

Unlike Freud's emphasis on drive conflict, Kohut's emphasis is clearly on person-to-person interactions. Kohut suggests that one way to conceptualize the difference between classical psychoanalysis and his own self-psychology is to contrast the traditions of "Guilty Man" and "Tragic Man."

Guilty Man is the concept of persons as struggling always toward the satisfaction of their drives. They are pictured in classical psychoanalysis as living under the domination of the pleasure principle, striving endlessly to reconcile inner conflict. They are frequently blocked from their goal of tension reduction by their own inadequacies or those of the people who raised them.

Tragic Man, by contrast, is Kohut's picture of people struggling to fulfill the aims of their nuclear selves. That is to say, Tragic Man is attempting to express the pattern of his or her very being, the pattern of the ambitions and ideals that comprise the self-expressive goals of a human life (1977, p. 133). Where Guilty Man is driven, Tragic Man yearns.

An Illustration: Reinterpretation of the Oedipus Complex

As an example of the differences between Kohut's self-psychology and classical psychoanalysis, consider Kohut's interpretation of the child's experiences during the phallic phase of development.

In classical theory, this central development-instinctual conflict is the source of a variety of weaknesses and unresolved guilts in the area of identity. Kohut, on the other hand, prefers to view the Oedipus conflict as the source of potential strengths.

Without a firm sense of self, a cohesive and continuous realization of "who I am," an Oedipus conflict cannot take place (1977, p. 227). "Unless the child sees himself as a delimited, abiding, independent center of initiative, he is unable to experience the object-instinctual desires that lead to the conflicts and secondary adaptations of the Oedipal period" (1977, p. 227).

With the focus on the positive aspects of the oedipal period, Kohut suggests that the typical oedipal desires are experienced by the child as assertive-possessive, affectionate-sexual urges to possess the opposite-sexed parent, combined with assertive, self-confident, competitive feelings toward the same-sexed parent. Parents will typically react to both sets of feelings with different, contradictory feelings of their own. On the one hand, they will become counteraggressive toward the child's aggression, and on the other will "react with pride and joy to the child's developmental achievement, to his vigor and assertiveness" (1977, p. 230).

When parents are able to respond in *both* ways to the child's Oedipal feelings—neither overdoing the aggression nor exaggerating the joy and pride in assertiveness—they promote the child's mental health and capacity for self-confidence. "If the little boy, for example, feels that his father looks upon him proudly as a chip off the old block and allows him to merge with him and with his adult greatness, then

his Oedipal phase will be a decisive step in self-consolidation and self-pattern-firming. . . ." (Kohut, 1977, p. 234).

What, in other words, is the Oedipus complex of the child who has entered the Oedipal phase with a firmly cohesive self and who is surrounded by parents who themselves have healthy cohesive and continuous selves? It is my impression . . . that the normal child's Oedipal experiences . . . contain, from the beginning and persisting throughout, an admixture of deep joy that, while unrelated to the content of the Oedipus complex in the traditional sense, is of the utmost developmental significance within the framework of the psychology of the self. (Kohut, 1977, pp. 235-236)

Parents who themselves are cohesive personalities will pass along their joy in living to their child. Kohut, in essence, asks whether the Oedipus complex is not more joyful, less conflicted, less violent, and less wounding to self-esteem than classical theory would have it (Kohut, 1977, p. 246). Could it be, he asks, that the classical version of the Oedipus complex exists only in the case of the child whose parents are themselves narcissistically wounded?

When Selfobjects Fail: The Injured Self

Psychological disorder from the perspective of Kohut's theory is no longer viewed in terms of the ego's failures to balance reality, id wishes, and superego judgments. Abnormal psychological functioning is pictured in Kohut's theory as the result of defects in the formation of a cohesive self. Such defects represent developmental insults to normal narcissism. When the insult or injury is sufficiently intense, characteristic pathological distortions are introduced into the infant's developing self. Kohut has described four such distortions that correspond to four different kinds of Selfobject failure (Kohut & Wolff, 1978):

1. *The understimulated self* that develops in the child whose Selfobjects are seriously unattuned to his or her self-needs for mirroring and idealizing. The self loses vitality, and in later life, the mirrorless and ideal-less self experiences itself as deadened, empty, and numbed. Such people may turn to momentary and risky ways of experiencing "aliveness" in the abuse of drugs and alcohol, sexual adventurism, or compulsive gambling. But all such artificial "self-stimulants" can provide only fleeting experiences of an alive self, and even those flashes of aliveness may be experienced as alien intrusions from the outside world. The person's self even has a quality of alien, depersonalized existence.
2. *The fragmenting self* is formed in the child whose Selfobjects have inflicted some definite narcissistic injury on the child at a particularly vulnerable moment. The child's self-esteem is overtaxed in the face of humiliation that proves permanently damaging. As a result, the person experiences self as fragmented, uncoordinated, and lacking balance and cohesion. Hypochondriacal complaints of vague pains and chronic but undefinable illness may characterize the person's daily life. At base, the person experiences self as sickened, weakened, and at the mercy of life.
3. *Overstimulated self* develops in the child who is exposed to Selfobjects who inappropriately stimulate either the child's ambitions or ideals. If the

grandiose ambitions-pole of the self is stimulated intensely, the result is a self that attempts to avoid situations where the person may become the center of attention. Archaic "greatness fantasies" stimulated by the Selfobjects arouse much anxiety in adulthood and push the person to hide the self from scrutiny.

If, on the other hand, the ideals-pole of the self was inappropriately responded to by the Selfobjects, the result is a persistent need to merge with idealized people and share in their greatness. But such a need to merge with them can also be experienced as threatening because one loses one's self in a fusion with another. Thus the person is trapped: He or she is "ideal hungry" but afraid to be devoured by his or her own hunger.

4. *Overburdened self* is embodied in the child whose Selfobjects did not provide opportunities for the child to merge with their strength and calmness. The overburdened self that develops lacks an ability to soothe itself, and the person experiences the world as a threatening, dangerous, inimical place. Any stimulation is overwhelming and fearful, and there is no place to turn for comfort.

It should be clear from Kohut's various conceptualizations that he has attempted to move away from a drive model of psychological functioning toward a more interpersonal and phenomenological viewpoint. In fact, Kohut argues in his last and posthumously published book that the curative ingredient in psychoanalytic treatment is the analyst's ability to teach the patient how to look for and use healthy Selfobjects:

According to self-psychology, then, the essence of the psychoanalytic cure resides in a patient's newly acquired ability to identify and seek out appropriate Selfobjects—both mirroring and idealizable—as they present themselves in his realistic surrounding and to be sustained by them. (Kohut, 1984, p. 77)

A FINAL WORD ON HEINZ KOHUT

Heinz Kohut's self-theory is the attempt to view personality development and the various ways in which it can go wrong in the light of the person's own evaluation of his or her success or failure in mastering the obstacles of life. The narcissistically injured patient, with whom Kohut primarily deals, evidences the kind of deficits and misinterpretations of reality that only make sense if a narcissistically damaged nuclear-self is postulated beyond the three agencies of the ego, id, and superego. Kohut perhaps summarizes his own contribution best when he explains the goal of psychoanalytic therapy with the narcissistically wounded personality:

The successful end of the analysis of narcissistic personality disorders has been reached, when, after a proper termination phase has established itself and has been worked through, the analysand's formerly enfeebled or fragmented nuclear-self—his nuclear ambitions and ideals in cooperation with certain groups of talents and skills—has become sufficiently strengthened and consolidated to be able to function as a more or less self-propelling, self-directed, self-sustaining unit which provides a

central purpose to his personality and gives a sense of meaning to his life. (Kohut, 1977, pp. 138-139)

There is no doubt that Kohut wishes to preserve the essence of psychoanalysis; but there is as little doubt that he has moved psychoanalysis toward the humanistic position of such theorists as Carl Rogers and Karen Horney in which integration and personal purposiveness are the criteria of personality health.

EVALUATING OBJECT RELATIONS THEORY

Indebted as they were to classical psychoanalysis, Klein, Winnicott, and Kohut each in their own way, advanced psychoanalysis from a drive theory to an interpersonal, transactional, and highly developmental model of personality. But intellectual debts are still debts. Like the parent theory from which these object-relations models emerged, each of them shares the strengths and weaknesses of psychodynamic formulations.

Refutability of Object Relations Theory

It is ironic that the great strength of object relations theory—a concern with the developmental consequences of intimate relationships—is also its greatest scientific weakness. Because the major interest of each theorist in this chapter was the unconscious dynamics, rather than the observable interpersonal transactions, of relationships, most of Klein's, Winnicott's and Kohut's hypotheses are untestable. What transpires in the "mind" of the baby as it interacts with mother can only ever be an inference.

Some inferences impress us as more reasonable than others, but reasonableness is not equivalent to refutability. Klein's formulations appear on close examination to be wanting both in the consistency of their logic and in the vast distance between her inferences and the observations on which they are putatively based. Winnicott's proposals, influenced by Klein, lie closer to pragmatic common sense. Unfortunately, however, with the single exception of the transitional object, Winnicott's hypotheses are still inferences about unconscious dynamics that lie too distant from the possibility of empirical test. Kohut's formulations, more philosophical than his colleagues, are nevertheless similarly speculative.

What can we conclude? In some respects, object relations theory represents no improvement in refutability relative to classical psychoanalysis. Indeed in some ways—including reliance on the death instinct, emphasis on innate aggression, reliance on paradoxical formulations—object relations theory represents a regression.

Human Agency in Object Relations Theory

Each theorist in this chapter shares more with the ego psychologists than with classical psychoanalytic theory on the dimension of active-versus-passive agency. If we ranked the three theorists from the least-active to the most-active conception of agency, the order would be: Klein, Kohut, Winnicott. Klein's formulation preserves substantial elements of the classical drive theory and its reliance on a reactive model

of the nervous system. Kleinian babies are tense infants who reactively discharge their drives on to available objects. Kohut's model clearly pictures humans as active constructors of their social reality, but his aim, necessarily, was a clinical one that emphasized the aberrant functioning of wounded people reacting to significant others who inflict their wounds. Winnicott, by far, is the theorist who most completely comprehends people from the earliest days of their lives as collaborative constructors of social reality. Winnicott's concepts of the infant's progress from omnipotent magical thinking to object relating and on toward *using the object by constructing it, destroying it, and happily rediscovering it surviving in reality* are active agent concepts. They are even interactive concepts of human agency. Unfortunately, they are also fuzzily metaphysical. No one is perfect.

The Idiographic Emphasis of Object Relations Theory

Shared with orthodox psychoanalysis is an almost religious fervor for understanding the individual. Personality development, and the ways in which it can go wrong, are strictly "one person at a time" phenomena for object relations theorists. It could hardly be otherwise for any theory with psychodynamic aspirations. The intention, however, is to generate clinical data that will by sheer accretion eventually cohere into nomothetic "laws" or rules of predictable behavior. But in object relations theory, as in Freud's pioneering attempts, that intention is stillborn. If there is a nomothetic principle *somewhere* in these formulations, then it is to be found in Winnicott's observations in the "set situation" or perhaps in the apparently universal human need for transitional objects.

SOME SUMMARY, SOME CONCLUSIONS

Object relations theory advanced Freud's orthodox model in two ways. First, a more ambitiously developmental perspective based on direct clinical work with children was introduced into psychoanalysis. Second, Freud's passing references to the ego's propensity to retain the character of its lost objects was expanded substantially. Intimate relations, rather than drive gratification, became both the medium and the message of psychoanalysis. Unlike the neo-Freudians, whom we consider in later chapters, the object relations theorists wanted to preserve as much of orthodox psychoanalysis as they could.

Melanie Klein

Beginning with the observations of her own children, Melanie Reizes Klein's (1882-1960) earliest formulations were more or less overly enthusiastic educational applications of classical theory. She initially presented her formulations as "psychoanalytic educational upbringing" designed to be a kind of prophylaxis of the child's mind. In a number of other ways, Klein took Freud at his word, and then extended the words beyond anything Freud intended. She soon pushed psychoanalytic understanding backwards in time to the earliest days of life, where eventually she found a fully functioning ego, superego, and a remarkably active aggressive drive. She credited

even the youngest child with an active unconsciously imaginative capacity, called "phantasy," to construct images of the important people in their lives. Phantasy images are real to the infant, as real as the people from whom they are derived and on whom they will eventually be projected. Klein's work is sometimes seen as a feminist corrective to Freud's male-dominated theory. In contrast to Freud's emphasis on the importance of the penis for both genders, Klein placed the female breast, the child's first love and most enduring love object, at the center of her psychological world.

Klein's conception of the infant pictures an inherently aggressive, sadistic, and opportunistic creature who becomes frightened by its own aggression. To protect itself from the retaliation it imagines its love objects might enact, the infant splits objects into good and bad. The worried infant anticipates persecution from its bad objects and idealizes its good ones for protection.

With time, Klein moderated the role of aggression in her theory, supplementing it with formulations of anxiety, guilt, envy, and reparation. The infant was now understood as envying the good object (breast) because of its bountiful goodness. Phantasies of destroying the good object not only evoke anxiety but provoke guilt feelings. The need to repair the love-object emerges and the infant omnipotently believes that it can accomplish this magical feat.

These various landmarks in the infant's progress toward conceptualizing the mother as a real person were called "positions" by Klein to emphasize that they are ongoing, lifelong processes. The first developmental position was called the *paranoid position* because the central anxiety is the infant's fear of its own annihilation. By a convoluted twist of logic, Klein argued that the infant fears that the destroyed object may reconstitute itself inside the infant and reinitiate its persecution. At a later moment in development, anxiety or concern for the welfare of the object becomes dominant. When the infant comprehends that the mother-as-a-person is in jeopardy from its own rage, the *depressive position* is entered. Now the baby's central concern is to protect the good object from its own attacks and those mounted against the mother by internalized bad objects. To supplement the reparative defensive strategy, the ego may temporarily adopt what Klein called the *manic position*. This developmental phase is marked by the need to take omnipotent control over the object, dominating it by exerting the power of life and death over it, and protecting it from its own sadistic impulses.

Although Klein originally proposed *splitting* as an elementary and primitive infantile defense against the recognition that good and bad object are one, she elaborated the concept into a series of complex developmental maneuvers. *Splitting* eventually referred to object division (good and bad), ego defensive splitting or repressive dissociation, object relations splitting (love and hate), and even splitting of enduring personality structures such as the id and superego. A supplementary and related defense is *projective identification*, whereby the infant identifies with the split-off good object and distances itself from the split-off bad object. But the target of the projection, mother, may find that the infant behaves in ways that subtly coerce her behavior into conformity with the infant's projection. Projective identification can thus be a kind of self-fulfilling prophecy by which the projector manipulates the projectee to comply with the wish embodied in the projection.

Klein's model of infant development relies on major inferences about the infant's mind. It strikes many observers that Klein's specific deductions tell us less about the infant's mind than they do about what was on Klein's mind.

D.W. Winnicott

Trained as a pediatrician, Donald Woods Winnicott (1896-1971) brought to psychoanalysis a pragmatic sensibility rooted in common sense. He had a gift for communicating with children and often could employ the simplest of games as diagnostic assessments. The squiggle game and his observations of babies mouthing a shiny tongue depressor (the "spatula") were part of Winnicott's consultative approach to child psychiatry.

He transferred that same flexible, spontaneous attitude to his psychoanalytic clinical work and to his theoretical formulations. Influenced by Melanie Klein, Winnicott was nevertheless adamant trying to maintain his intellectual and creative independence. He understood infants as collaborators rather than as sadistic aggressors. While he found value in Klein's developmental "positions," he made every effort to depathologize them by focusing on the achievements of the infant in coping with its interpersonal world. Life is normally difficult, Winnicott argued, and most babies momentarily display some forms of behavior that appears pathological. But on closer examination, coupled with a willingness to tolerate momentarily eccentric or disruptive behavior, adults soon discover that most children can cope with life's real difficulties if their mothers can provide sufficiently secure and comforting *holding*.

The basic developmental tasks for the infant whose mother provides the physical and metaphorical holding that facilitates development are threefold: integration, personalization, and realization. *Integration* refers to the organization of personality facilitated by the mother's attention to satisfying her infant's needs reliably. *Unintegration*, the Winnicottian opposite of integration, is a primordially natural phase of development that the infant does not find distressing. *Personalization* is Winnicott's term for the infant's achievement of linking inner and outer reality by recognizing the boundaries of its own physical body. He meant that the baby "personalizes"—takes possession of—its body with help from mother's ministrations so that "this is *my* finger" begins to have real meaning. Finally, *realization* was Winnicott's term for the baby's acceptance of external reality as real, as objective and as enduring contrasted with the inner world of fantasy. Here the mother helps her child achieve "disillusionment": the understanding that illusion, however satisfying, is simply not shared reality.

Winnicott suggested that the "ordinary devoted mother" provides "good enough mothering" to permit her child to master its own aggression, come to grips with life's real difficulties, and develop a spontaneous, authentic self that he termed the *True Self*. By contrast, "not good enough" mothering, exhibited, for example, by the depressed mother, the psychiatrically ill or the neglectful mother, promotes the development of a protective mask-like self, called the *False Self*. Children can develop differing levels of False Self protection that vary in degree of maladaptiveness. At the extremely maladaptive end of the continuum is the False Self that functions to conceal completely the spontaneous True Self in an effort to protect it from manipulation in social contact. At the opposite end of the spectrum, most children develop a kind

of socially cooperative False Self that serves to facilitate social success rather than to wall off the True Self. Between these extremes, children find healthy and not so healthy ways of protecting their inner lives from "impingement" and potential betrayal. But it was Winnicott's belief that the more protectively powerful the False Self grew, the less "alive," spontaneous, and playful could the True Self feel.

As part of her skilled and empathic "holding," the good enough mother provides just those things that the baby needs at just those moments when the baby is ready for them. In Winnicott's famous phrase, "There's no such thing as a baby." Babies are best understood as an integral part of the "nursing couple." Winnicott envisioned the mother-child relationship as a collaboration of two very unequal partners. The mother's task is to "shrink down" to baby-size to understand her infant's needs because the baby cannot expand to adult size to tell her what they might be. The good enough mother provides sufficient holding for the baby to master its most primitive fears, the unthinkable anxieties:

- Going to pieces,
- Falling forever,
- Having no relationship to the body,
- Having no orientation, and
- Complete isolation because of there being no means for communication.

Along the way, the infant learns the difference between those parts of self and mother which belong to "me" and those that are "not-me." Once this division between inner and outer reality is achieved, the infant can tolerate increased separation from its love-objects. To bridge the separation, a *transitional object*, the infant's first "not-me" possession will be "created" in collaboration with the mother. A bit of soft blanket, a stuffed toy, even a handkerchief or piece of clothing ("the niffle"), can serve the role of transitional object. It is baby's choice in cooperation with a mother who facilitates and supports the choice.

Toward the end of his life, when personal survival was at issue, Winnicott created one final developmental distinction between *relating* to and *using* an object. On the basis of a dream evoked by reading Jung's autobiography, Winnicott came to the insight that the infant has to fantasize destroying its love object to discover that the object in reality nevertheless survives. This infantile discovery permits the infant not only to relate to the object in a dependent way, but to trust sufficiently in the reliability and durability of the object to *use* the object to facilitate its own growth toward independence. As Winnicott pointed out, the progression from relating to using involves creation by destruction.

Heinz Kohut

Heinz Kohut (1913-1981) proposed a psychoanalytic self-theory in which the classical tripartite division of the mind is not adequate to the task of accounting for the development of a person's ambitions and ideals. Beginning his work with narcissistically wounded patients, Kohut argued that classical drive theory excludes from its account of normal development some important interpersonal interactions

responsible for the emergence of empathic understanding, self-esteem, and healthy adaptation to life.

The nuclear-self, in Kohut's formulation, is structured around the bipolar anchor points of ambition and ideals. Between these poles lies a tensions arc of psychological activities representing the forces that drive the individual to attain his or her goals. Classical psychoanalytic theory regards humans as struggling under the domination of the pleasure principle to reduce the tension of their instincts. A picture of a person as *Guilty Man* emerges from such a viewpoint, whereas Kohut's self-formulation portrays a *Tragic Man* conception of personality, whereby persons are interpreted as struggling to fulfill the aims of the ambitions and ideals contained in the bipolar nuclear-self.

In all, ego psychology has greatly expanded the confines of classical theory. No longer is a human being an "assembly of minds" or a battlefield on whose terrain the battalions of the mind erect obstacles, conduct assaults, and sustain defeats. No longer is psychoanalytic psychology restricted to study of unhealthy personality disasters. The whole span of life, from birth through adulthood, and the whole range of possible adaptations, from inhibited and fearful withdrawals to psychotic and fragmented separations from reality to masterful and efficacious coping, are accepted as suitable areas for a general psychoanalytic psychology to explore.

Taken as a loosely related group of ideas, object relations theories share the strengths and weaknesses of their parent model, classical psychoanalysis. They rely on untestable, irrefutable inferences about the infantile mind. The three theorists in this chapter represent advances over orthodox psychoanalysis in conceptualizing humans as active agents, but ranked on their conceptualizations from least active to most active, the list puts Klein at the bottom, Kohut in the middle, and Winnicott at the top rank. Idiographically focused on the individual case, objects relations theorists intend to generate universal or nomothetic, law-like principles, but they have not done so thus far.

FOR FURTHER READING

Scope and History of Object Relations Theories

A thorough and readable overview of the history and variety of object relations theories is given by Frank Summers in his *Object Relations Theories and Psychopathology* (1994, New York: Academic Press). Judith M. Hughes provides a comparison of the lives and work of Klein, Winnicott, and Fairbairn in her *Reshaping the Psychoanalytic Domain* (1989, Berkeley, CA: University of California Press). Jay R. Greenberg and Stephen A. Mitchell survey the details, philosophy, and metapsychology of a wide range of object relations theories in their *Object Relations in Psychoanalytic Theory* (1983, Cambridge, MA: Harvard University Press). Roy Schafer's edited volume, *The Contemporary Kleinians of London*. (1997, New York: International Universities Press) fulfills the aims of its title.

Melanie Klein

The most detailed and compelling biography of Klein is Phyllis Grosskurth's psychologically insightful and monumental *Melanie Klein: Her World and Her Work*. (Cambridge, MA: Harvard University Press, 1989). Klein never wrote a simple overview of her fully developed theory, but two of her books taken together provide a good introduction. The first is Klein's *Envy and Gratitude* (*The Writings of Melanie Klein*, Vol III, 176-235; New York: The Free Press, 1975). The second is Klein's *The Psychoanalysis of Children* (*The Writings of Melanie Klein*, Vol II, New York: The Free Press, 1975). Julia Segal's, *Melanie Klein*. (London: Sage Publications, 1992) gives a sympathetic overview of Klein's life and work.

D. W. Winnicott

The best introduction to Winnicott's own writings are the papers collected into D.W. Winnicott's *The Maturation Processes and the Facilitating Environment* (Madison, CT: International Universities Press, 1965). Winnicott's *Playing and Reality* (Harmondsworth, Great Britain: Penguin, 1971; a variety of paperback editions available) is easy reading and a worthwhile supplement to Winnicott's professional papers.

Heinz Kohut

Heinz Kohut's chief publications include *The Analysis of the Self* (New York: International Universities Press, 1971), which presents the concept of the narcissistic personality; and his *The Restoration of the Self* (New York: International Universities Press, 1977), which more comprehensively elaborates his theory of the self, treatment for the narcissistic disorders, and his speculations on the flaws in classical psychoanalytic theory. Kohut's final statement in which he answers his critics has been posthumously published as *How Does Analysis Cure?* (Chicago: University of Chicago Press, 1984) and contains some important clarifications of his position.