9. The Theory of the Parent-Infant Relationship

D. W. Winnicott

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

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

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

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

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

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

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

In the writings of Freud most of the formulations concerning infancy derive from a study of adults in analysis. There are some childhood observations (‘Cotton reel’ material (5)), and there is the analysis of Little Hans (3). At first sight it would seem that a great deal of psychoanalytic theory is about early childhood and infancy, but in one sense Freud can be said to have neglected infancy as a state. This is brought out by Functi for gra the reality-fancy c

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The infant's environment is, it is necessary, if the everything shall seem to tence and the pleasure earliest infancy; and to a of a true 'not-me' is a phantasmagoria and to the ons concerning infancy are some childhood there is the analysis of a great deal of psycho-fancy, but in one sense a state. This is brought out by a footnote in 'Formulations on the Two Principles of Mental Functioning' (4, p. 220) in which he shows that he knows he is taking for granted the very things that are under discussion in this paper. In the text he traces the development from the pleasure-principle to the reality-principle, following his usual course of reconstructing the infancy of his adult patients. The note runs as follows:

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

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

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

The words: 'provided one includes with it the care it receives from its mother' have great importance in the context of this study. The infant and the maternal care together form a unit.1 Certainly if one is to study the theory of the parent-infant relationship one must come to a decision about these matters, which concern the real meaning of the word dependence. It is not enough that it is acknowledged that the environment is important. If there is to be a discussion of the theory of the parent-infant relationship, then we are divided into two if there are some who do not allow that at the earliest stages the infant and the maternal care belong to each other and cannot be disentangled. These

1I once said: 'There is no such thing as an infant', meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant. (Discussion at a Scientific Meeting of the British Psycho-Analytical Society, circa 1940). Was I influenced, without knowing it, by this footnote of Freud's?
two things, the infant and the maternal care, disentangle and dissociate
themselves in health; and health, which means so many things, to some
extent means a disentanglement of maternal care from something which
we then call the infant or the beginnings of a growing child. This idea
is covered by Freud’s words at the end of the footnote: ‘the dominance
of the pleasure principle can really come to an end only when a child
has achieved complete psychical detachment from its parents’. (The
middle part of this footnote will be discussed in a later section, where
it will be suggested that Freud’s words here are inadequate and mis-
leading in certain respects, if taken to refer to the earliest stage.)

The Word ‘Infant’

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

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

I am here supporting the view that the main reason why in infant

¹I have tried to show the application of this hypothesis to an understanding of
psychosis in my paper: ‘Psychoses and Child Care’ (15).

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

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

Historical

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

Ego mechanisms of defence were gradually formulated.3 These mechanisms were assumed to be organized in relation to anxiety which derived either from instinct tension or from object loss. This part of psycho-analytic theory presupposes a separateness of the self and a structuring of the ego, perhaps a personal body scheme. At the level of the main part of this paper this state of affairs cannot yet be assumed. This discussion centres round the establishment of precisely this state of affairs, namely the structuring of the ego which makes anxiety from instinct tension or object loss possible. Anxiety at this early stage is not castration anxiety or separation anxiety; it relates to quite other things, and is, in fact, anxiety about annihilation (cf. the aphanisis of Jones).

In psycho-analytic theory ego mechanisms of defence largely belong

3Researches into defence mechanisms which followed Anna Freud's 'The Ego and its Mechanisms of Defence' (1) have from a different route arrived at a re-evaluation of the role of mothering in infant care and early infant development. Anna Freud (2) has reassessed her views on the matter. Willi Hoffer also has made observations relating to this area of development (8). My emphasis in this paper, however, is on the importance of an understanding of the role of the early parental environment in infant development, and on the way this becomes of clinical significance for us in our handling of certain types of case with affective and character disorders.
to the idea of a child that has an independence, a truly personal defence organization. On this borderline the researches of Klein add to Freudian theory by clarifying the interplay of primitive anxieties and defence mechanisms. This work of Klein concerns earliest infancy, and draws attention to the importance of aggressive and destructive impulses that are more deeply rooted than those that are reactive to frustration and related to hate and anger; also in Klein’s work there is a dissection of early defence against primitive anxieties, anxieties that belong to the first stages of the mental organization (splitting, projection, and introjection).

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

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

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

One half of the theory of the parent-infant relationship concerns the infant, and is the theory of the infant’s journey from absolute dependence, through relative dependence, to independence, and, in parallel, the infant’s journey from the pleasure principle to the reality principle, and from autoerotism to object relationships. The other half of the theory of the parent-infant relationship concerns maternal care, that is

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1 I have given a detailed account of my understanding of Melanie Klein’s work in this area in two papers (16, 21) See Klein (9, p. 297).

2 For a clinical example see (17).
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to say the qualities and changes in the mother that meet the specific and developing needs of the infant towards whom she orientates.

A. THE INFANT

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

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

The Inherited Potential and Its Fate

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

(a) Holding.

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

The term 'holding' is used here to denote not only the actual physical holding of the infant, but also the total environmental provision prior to the concept of living with. In other words, it refers to a three-dimensional or space relationship with time gradually added. This overlaps with, but is initiated prior to, instinctual experiences that in time would determine object relationships. In includes the management of experiences that are inherent in existence, such as the completion (and therefore the noncompletion) of processes, processes which from the outside may seem to be purely physiological but which belong to infant psychology and take place in a complex psychological field, determined by the awareness and the empathy of the mother. (This concept of holding is further discussed below.)

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

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

Infant Development During the Holding Phase

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

- primary process
- primary identification
- auto-erotism
- primary narcissism

are living realities.

In this phase the ego changes over from an unintegrated state to a structured integration, and so the infant becomes able to experience anxiety associated with disintegration. The word disintegration begins to have a meaning which it did not possess before ego integration became a fact. In healthy development at this stage the infant retains the capacity on the other hand of not being able to enjoy the mother during this phase. The infant's sense of security is a key factor in the way in which he gradually becomes capable of relating to the world outside of the immediate environment. During this important stage of development, the child begins to experience the world as a separate entity, distinct from his own self.

At the same time, the child begins to develop an awareness of the boundaries that separate him from others. This awareness is influenced by the dynamics of the holding relationship, which provides a sense of security and a basis for the development of a healthy sense of self. The holding relationship is characterized by a high degree of acceptance and responsiveness, which allows the infant to develop a trusting relationship with the caregiver. This trust is essential for the healthy development of the child's sense of self and his ability to relate to the world outside of the immediate environment.

*For an earlier discussion of how the infant begins to experience the world as a separate entity, see the works of John Bowlby and other authors in the field of attachment theory.*

*Here the word 'familiar' is used to describe the way in which the infant becomes familiar with the environment and its inhabitants.*
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the capacity for re-experiencing unintegrated states, but this depends
on the continuation of reliable maternal care or on the build-up in the
infant of memories of maternal care beginning gradually to be perceived
as such. The result of healthy progress in the infant’s development
during this stage is that he attains to what might be called ‘unit status’.
The infant becomes a person, an individual in his own right.

Associated with this attainment is the infant’s psychosomatic exist-
ence, which begins to take on a personal pattern; I have referred to
this as the psyche indwelling in the soma. The basis for this indwelling
is a linkage of motor and sensory and functional experiences with the
infant’s new state of being a person. As a further development there
comes into existence what might be called a limiting membrane, which
to some extent (in health) is equated with the surface of the skin, and
has a position between the infant’s ‘me’ and his ‘not-me’. So the infant
comes to have an inside and an outside, and a body-scheme. In this
way meaning comes to the function of intake and output; moreover, it
gradually becomes meaningful to postulate a personal or inner psychic
reality for the infant.7

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

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

6 For an earlier statement by me on this issue see (13).
7 Here the work on primitive fantasy, with whose richness and complexity we are
familiar through the teachings of Melanie Klein, becomes applicable and appropriate.
A further development is in the capacity for object relationships. Here the infant changes from a relationship to a subjectively conceived object to a relationship to an object objectively perceived. This change is closely bound up with the infant's change from being merged with the mother to being separate from her, or to relating to her as a separate and 'not-me'. This development is not specifically related to the holding, but is related to the phase of 'living with' . . .

Dependence

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

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

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

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

Isolation of the Individual

Another phenomenon that needs consideration at this phase is the hiding of the core of the personality. Let us examine the concept of a central or true self. The central self could be said to be the inherited potential which is experiencing a continuity of being, and acquiring in its own way and at its own speed a personal psychic reality and a personal body scheme. It seems necessary to allow for the concept of the isolation of

*In another paper (22) I have tried to discuss another aspect of this developmental phase as we see it in adult health. Cf. Greenacre (7).
for object relationships.

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this central self as a characteristic of health. Any threat to this isolation of the true self constitutes a major anxiety at this early stage, and defences of earliest infancy appear in relation to failures on the part of the mother (or in maternal care) to ward off impingements which might disturb this isolation.

Impingements may be met and dealt with by the ego organization, gathered into the infant's omnipotence and sensed as projections. On the other hand they may get through this defence in spite of the ego support which maternal care provides. Then the central core of the ego is affected, and this is the very nature of psychotic anxiety. In health the individual soon becomes invulnerable in this respect, and if external factors impinge there is merely a new degree and quality in the hiding of the central self. In this respect the best defence is the organization of a false self. Instinctual satisfactions and object relationships themselves constitute a threat to the individual's personal going-on-being. Example: a baby is feeding at the breast and obtains satisfaction. This fact by itself does not indicate whether he is having an ego-syntonic id experience or, on the contrary, is suffering the trauma of a seduction, a threat to personal ego continuity, a threat by an id experience which is not ego-syntonic, and with which the ego is not equipped to deal.

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

Annihilation

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

In this phase which is characterized by the essential existence of a holding environment, the 'inherited potential' is becoming itself a 'con-

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

*I have described clinical varieties of this type of anxiety from a slightly different aspect in a previous paper (12).
tinuity of being'. The alternative to being is reacting, and reacting
interrupts being and annihilates. Being and annihilation are the two
alternatives. The holding environment therefore has as its main function
the reduction to a minimum of impingements to which the infant must
react with resultant annihilation of personal being. Under favourable
conditions the infant establishes a continuity of existence and then
begins to develop the sophistications which make it possible for imp-
ingements to be gathered into the area of omnipotence. At this stage
the word death has no possible application, and this makes the term
death instinct unacceptable in describing the root of destructiveness.
Death has no meaning until the arrival of hate and of the concept of the
whole human person. When a whole human person can be hated, death
has meaning, and close on this follows that which can be called maiming;
the whole hated and loved person is kept alive by being castrated or
otherwise maimed instead of killed. These ideas belong to a phase later
than that characterized by dependence on the holding environment.

Freud’s Footnote Re-examined

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

B. THE ROLE OF THE MATERNAL CARE

I shall now attempt to describe some aspects of maternal care, and
especially holding. In this paper the concept of holding is important,
and a further development of the idea is necessary. The word is here
THE THEORY OF THE PARENT-INFANT RELATIONSHIP

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used to introduce a full development of the theme contained in Freud’s phrase ‘... when one considers that the infant—provided one includes
with it the care it receives from its mother—does almost realize a
psychical system of this kind.’ I refer to the actual state of the infant-
mother relationship at the beginning when the infant has not separated
out a self from the maternal care on which there exists absolute de-
pendence in a psychological sense.

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

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

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

Holding

Protects from physiological insult.

Takes account of the infant’s skin sensitivity—touch, temperature,
auditory sensitivity, visual sensitivity, sensitivity to falling (action of
avity) and of the infant’s lack of knowledge of the existence of any-
thing other than the self.

It includes the whole routine of care throughout the day and night,
and it is not the same with any two infants because it is part of the
infant, and no two infants are alike.

Also it follows the minute day-to-day changes belonging to the in-
fant’s growth and development, both physical and psychological.

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

Holding includes especially the physical holding of the infant, which
is a form of loving. It is perhaps the only way in which a mother can
show the infant her love of it. There are those who can hold an infant


11 Reminder: to be sure of separating this off from object-relationships and instinct-
gratification I must artificially confine my attention to the body needs of a general kind.
A patient said to me: 'A good analytic hour in which the right interpretation is given at
the right time is a good feed.'
and those who cannot; the latter quickly produce in the infant a sense of insecurity, and distressed crying.

All this leads right up to, includes, and co-exists with the establishment of the infant’s first object relationships and his first experiences of instinctual gratification. ¹²

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

The mental health of the individual, in the sense of freedom from psychosis or liability to psychosis (schizophrenia), is laid down by this maternal care, which when it goes well is scarcely noticed, and is a continuation of the physiological provision that characterizes the prenatal state. This environmental provision is also a continuation of the tissue aliveness and the functional health which (for the infant) provides silent but vitally important ego support. In this way schizophrenia or infantile psychosis or a liability to psychosis at a later date is related to a failure of environmental provision. This is not to say, however, that the ill effects of such failure cannot be described in terms of ego distortion and of the defences against primitive anxieties, that is to say in terms of the individual. It will be seen, therefore, that the work of Klein on the splitting defence mechanisms and on projections and interceptions and so on, is an attempt to state the effects of failure of environmental provision in terms of the individual. This work on primitive mechanisms gives the clue to only one part of the story, and a reconstruction of the environment and of its failures provides the other part. This other part cannot appear in the transference because of the patient’s lack of knowledge of the maternal care, either in its good or in its failing aspects, as it existed in the original infantile setting.

Examination of One Detail of Maternal Care

I will give an example to illustrate subtlety in infant care. An infant is merged with the mother, and while this remains true the nearer the mother can come to an exact understanding of the infant’s needs the better.

¹² For further discussion of this aspect of the developmental processes see my paper (14).

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better. A change, however, comes with the end of merging, and this
end is not necessarily gradual. As soon as mother and infant are sepa-
rate, from the infant’s point of view, then it will be noted that the mother
tends to change in her attitude. It is as if she now realizes that the infant
no longer expects the condition in which there is an almost magical
understanding of need. The mother seems to know that the infant has
a new capacity, that of giving a signal so that she can be guided towards
meeting the infant’s needs. It could be said that if now she knows too
well what the infant needs, this is magic and forms no basis for an object
relationship. Here we get to Freud’s words: ‘It (the infant) probably
hallucinates the fulfiment of its internal needs; it betray its unpleasure,
when there is an increase of stimulus and an absence of satisfaction, by
the motor discharge of screaming and beating about with its arms and
legs, and it then experiences the satisfaction it has hallucinated.’ In
other words, at the end of merging, when the child has become separate
from the environment, an important feature is that the infant has to give
a signal.¹³ We find this subtlety appearing clearly in the transference in
our analytic work. It is very important, except when the patient is
regressed to earliest infancy and to a state of merging, that the analyst
shall not know the answers except in so far as the patient gives the
clues. The analyst gathers the clues and makes the interpretations, and
it often happens that patients fail to give the clues, making certain
thereby that the analyst can do nothing. This limitation of the analyst’s
power is important to the patient, just as the analyst’s power is impor-
tant, represented by the interpretation that is right and that is made at
the right moment, and that is based on the clues and the unconscious
cooperation of the patient who is supplying the material which builds
up and justifies the interpretation. In this way the student analyst some-
times does better analysis than he will do in a few years’ time when he
knows more. When he has had several patients he begins to find it
irksome to go as slowly as the patient is going, and he begins to make
interpretations based not on material supplied on that particular day by
the patient but on his own accumulated knowledge or his adherence for
the time being to a particular group of ideas. This is of no use to the
patient. The analyst may appear to be very clever, and the patient may
express admiration, but in the end the correct interpretation is a trauma,
which the patient has to reject, because it is not his. He complains that

¹³ Freud’s later theory of anxiety as a signal to the ego (6).
the analyst attempts to hypnotize him, that is to say, that the analyst is inviting a severe regression to dependence, pulling the patient back to a merging in with the analyst.

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

We see therefore that in infancy and in the management of infants there is a very subtle distinction between the mother's understanding of her infant's need based on empathy, and her change over to an understanding based on something in the infant or small child that indicates need. This is particularly difficult for mothers because of the fact that children vacillate between one state and the other; one minute they are merged with their mothers and require empathy, while the next they are separate from her, and then if she knows their needs in advance she is dangerous, a witch. It is a very strange thing that mothers who are quite uninstructed adapt to these changes in their developing infants satisfactorily and without any knowledge of the theory. This detail is reproduced in psycho-analytic work with borderline cases, and in all cases at certain moments of great importance when dependence in transference is maximal.

Unawareness of Satisfactory Maternal Care

It is axiomatic in these matters of maternal care of the holding variety that when things go well the infant has no means of knowing what is being properly provided and what is being prevented. On the other hand it is when things do not go well that the infant becomes aware, not of the fault of the mother being at fault where of the infant being at fault, a necessity of the reaction of the infant being at fault.

C. THE

It is important to note the changes holding the infant. If a phrase is the fact is that the infant may have been, necessary in spite of the fact of the infant to be affected. Do not subtle a subtext the woman's changes the child.

"In child to deal with the etiology of this in S. Delinquency:
that is to say, that the analyst is hence, pulling the patient back to the mothers of infants; mothers to be so good at the technique of things at the right moments, and hence separate from the mother has good things that are going on. The little signs that are supposed these things are missing, because just as if the infant were still infant. In this way the mother, by something worse than castrate to alternatives; either being in a being merged with the mother, or father, even of the seemingly good tried in the management of infants even the mother’s understanding by, and her change over to an infant or small child that difficult for mothers because of the state and the other; one minute require empathy, while the next he knows their needs in advance strange thing that mothers who anges in their developing infants edge of the theory. This detail is with borderline cases, and in all importance when dependence in

C. THE CHANGES IN THE MOTHER

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

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

Soon after conception, or when conception is known to be possible, the woman begins to alter in her orientation, and to be concerned with the changes that are taking place within her. In various ways she is

In character cases it is this ego-weakening and the individual’s various attempts to deal with it that presents itself for immediate attention, and yet only a true view of the etiology can make possible a sorting out of the defense aspect of this presenting symptom from its origin in environmental failure. I have referred to one specific aspect of this in the diagnosis of the antisocial tendency as the basic problem behind the Delinquency Syndrome (19).
encouraged by her own body to be interested in herself.\textsuperscript{15} The mother shifts some of her sense of self on to the baby that is growing within her. The important thing is that there comes into existence a state of affairs that merits description and the theory of which needs to be worked out.

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

A detailed description of the changes in orientation in a woman who is becoming or who has just become a mother would be out of place here, and I have made an attempt elsewhere to describe these changes in popular or non-technical language (23).

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

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

In the ordinary case the mother’s special orientation to the infant carries over beyond the birth process. The mother who is not distorted in these matters is ready to let go of her identification with the infant as the infant needs to become separate. It is possible to provide good initial care, but to fail to complete the process through an inability to let it come to an end, so that the mother tends to remain merged with her infant and to delay the infant’s separation from her. It is in any case a difficult thing for a mother to separate from her infant at the same speed at which the infant needs to become separate from her.\textsuperscript{16}

\textsuperscript{15} For a more detailed statement on this point see: ‘Primary Maternal Preoccupation’ (20).

\textsuperscript{16}Case-material to illustrate one type of problem that is met with clinically and relates to this group of ideas is presented in an earlier paper (11).
We be interested in herself. The mother feels on to the baby that is growing within her; there comes into existence a state of relatedness to the needs of a patient who is reliving these experiences, and this leads to similar changes of orientation, other, needs to be aware of the sensitivity of the patient's immaturity and the physical holding of as an extension of Freud's descriptive state of attentiveness. Changes in orientation in a woman who is a mother would be out of place here, where to describe these changes in a(23). These changes in orientation, and the concern of those who study the psyche, doubt there are many variations in normality. It is the degree of distortion he way or another identify themselves in them, and in this way they achieve a baby needs. This is a projective identification. The baby lasts for a certain length of time and loses significance. The mother who is not distorted by her identification with the infant as a child can provide good initial process through an inability to let it be as if it is something with no merged with her separation from her. It is in any case a state from her infant at the same speed and separate from her.

is point see: 'Primary Maternal Preoccupation'-problem that is met with clinically and in an earlier paper (11).

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

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

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

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

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

SUMMARY

(i) An examination is made of infancy; this is not the same as an examination of primitive mental mechanisms.
(ii) The main feature of infancy is dependence; this is discussed in terms of the holding environment.
(iii) Any study of infancy must be divided into two parts:
(a) Infant development facilitated by good enough maternal care;
(b) Infant development distorted by maternal care that is not good enough.
(iv) The infant ego can be said to be weak, but in fact is strong because of the ego support of maternal care. Where maternal care fails the weakness of the infant ego becomes apparent.
(v) Processes in the mother (and in the father) bring about, in health, a special state in which the parent is orientated to the infant, and is thus in a position to meet the infant’s dependence. There is a pathology of these processes.
(vi) Attention is drawn to the various ways in which these conditions inherent in what is here termed the holding environment can or cannot appear in the transference if at a later date the infant should come into analysis.

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