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MIND AND ITS RELATION TO THE PSYCHE-SOMA*

By D. W. WINNICOTT†

'To ascertain what exactly comprises the irreducible mental elements, particularly those of a dynamic nature, constitutes in my opinion one of our most fascinating aims. These elements would necessarily have a somatic and probably a neurological equivalent, and in that way we should by scientific method have closely narrowed the age-old gap between mind and body. I venture to predict that then the antithesis which has baffled all the philosophers will be found to be based on an illusion. In other words, *I do not think that the mind really exists as an entity*—possibly a startling thing for a psychologist to say [my italics]. When we talk of the mind influencing the body or the body influencing the mind we are merely using a convenient shorthand for a more cumbrous phrase....' (Jones, 1946.)

I give Ernest Jones in the form of a quotation by Scott because it was actually this paper of Scott's (1949) which stimulated me to try to sort out my own ideas on this vast and difficult subject. The body scheme with its temporal and spatial aspects provides a valuable statement of the individual's diagram of himself, and in it I believe there is no obvious place for the mind. Yet in clinical practice we do meet with the mind as an entity localized somewhere by the patient; a further study of the paradox that 'mind does not really exist as an entity' is therefore necessary.

Mind as a function of psyche-soma

To study the concept of mind one must always be studying an individual, a total individual, and including the development of that individual from the very beginning of psychosomatic existence. If one accepts this discipline then one can study the mind of an individual as it specializes out from the psyche part of the psyche-soma.

The mind does not exist as an entity in the individual's scheme of things provided the individual psyche-soma or body scheme has come satisfactorily through the very early developmental stages; mind is then no more than a special case of the functioning of the psyche-soma.

In the study of a developing individual the mind will often be found to be developing a *false entity*, and a *false localization*. A study of these abnormal tendencies must precede the more direct examination of the mind-specialization of the healthy or normal psyche.

We are quite used to seeing the two words mental and physical opposed and would not quarrel with their being opposed in daily conversation. It is quite another matter, however, if the concepts are opposed in scientific discussion.

The use of these two words physical and mental in describing disease leads us into trouble immediately. The psychosomatic disorders, half way between the mental and the physical, are in a rather precarious position. Research into psychosomatics is being held up,‡ to some extent, by the muddle to which I am referring. Also, neuro-surgeons are doing things to the normal or healthy brain in an attempt to alter or even improve mental states. These 'physical' therapists are completely at sea in their theory; curiously enough they seem to be leaving out the importance of the physical body, of which the brain is an integral part.

* A paper read before The Medical Section of the British Psychological Society, 14 December 1949 and revised October 1953.

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‡ This suggestion is reflected in a recent article by Ida Macalpine (1953).

Statement of psyche-soma development

Let us attempt, therefore, to think of the developing individual, starting at the beginning. Here is a body, and the psyche and the soma are not to be distinguished except according to the direction from which one is looking. One can look at the developing body or at the developing psyche. I suppose the word psyche here means the *imaginative elaboration of somatic parts, feelings, and functions*, that is, of physical aliveness. We know that this imaginative elaboration is dependent on the existence and the healthy functioning of the brain, especially certain parts of it. The psyche is not, however, felt by the individual to be localized in the brain, or indeed to be localized anywhere.

Gradually the psyche and the soma aspects of the growing person become involved in a process of mutual interrelation. This interrelating of the psyche with the soma constitutes an early phase of individual development (see Winnicott, 1945). At a later stage the live body, with its limits, and with an inside and an outside, is *felt by the individual* to form the core for the imaginative self. The development to this stage is extremely complex, and although this development may possibly be fairly complete by the time a baby has been born a few days, there is a vast opportunity for distortion of the natural course of development in these respects. Moreover, whatever applies to very early stages also applies to some extent to all stages, even to the stage that we call adult maturity.

Theory of mind

On the basis of these preliminary considerations I find myself putting forward a theory of mind. This theory is based on work with analytic patients who have needed to regress to an extremely early level of development in the transference. In this paper I shall only give one piece of illustrative clinical material, but the theory can, I believe, be found to be valuable in our daily analytic work.

Let us assume that health in the early development of the individual entails *continuity of being*. The early psyche-soma proceeds along a certain line of development provided its *continuity of being is not disturbed*; in other words, for the healthy development of the early psyche-soma there is a need for a *perfect* environment. At first the need is absolute.

The perfect environment is one which *actively adapts* to the needs of the newly formed psyche-soma, that which we as observers know to be the infant at the start. A bad environment is bad because by failure to adapt it becomes an *impingement* to which the psyche-soma (i.e. the infant) must *react*. This reacting disturbs the continuity of the going-on-being of the new individual. In its beginnings the good (psychological) environment is a physical one, with the child in the womb or being held and generally tended; only in the course of time does the environment develop a new characteristic which necessitates a new descriptive term, such as emotional or psychological or social. Out of this emerges the ordinary good mother with her ability to make active adaptation to her infant's needs arising out of her devotion, made possible by her narcissism, her imagination and her memories which enable her to know through identification what are her baby's needs.

The need for a good environment, which is absolute at first, rapidly becomes relative. *The ordinary good mother is good enough.* If she is *good enough* the infant becomes able to allow for her deficiencies by mental activity. This applies to meeting not only instinctual impulses but also all the most primitive types of ego-need, even including the need for negative care or an alive neglect. The mental activity of the infant turns a *good enough* environment into a perfect environment, that is to say, turns relative failure of adaptation into adaptive success. What releases the mother from her need to be near-perfect is the infant's understanding. In the ordinary course of events the mother tries not to introduce complications beyond those which the infant can understand and allow for; in particular she tries to insulate her baby from coincidences

and from other phenomena that must be beyond the infant's ability to comprehend. In a general way she keeps the world of the infant as simple as possible.

The mind, then, has as one of its roots a variable functioning of the psyche-soma, one concerned with the threat to continuity of being that follows any failure of (active) environmental adaptation. It follows that mind-development is very much influenced by factors not specifically personal to the individual, including chance events.

In infant care it is vitally important that mothers, at first physically, and soon also imaginatively, can start off by supplying this active adaptation, but also it is a characteristic maternal function to provide *graduated failure of adaptation*, according to the growing ability of the individual infant to allow for relative failure by mental activity, or by understanding. Thus there appears in the infant a tolerance in respect of both ego-need and instinctual tension.

It could perhaps be shown that mothers are released slowly by infants who eventually are found to have a low I.Q. On the other hand, an infant with exceptionally good brain, eventually giving a high I.Q., releases the mother earlier.

According to this theory then, in the development of every individual, the mind has a root, perhaps its most important root, in the need of the individual, at the core of the self, for a perfect environment. (In this connexion, I might refer to my view of psychosis as an environmental deficiency disease (Winnicott, 1953).) There are certain developments of this theory which seem to me to be important. Certain kinds of failure on the part of the mother, especially erratic behaviour, produce over-activity of the mental functioning. Here, in the overgrowth of the mental function reactive to erratic mothering, we see that there can develop an opposition between the mind and the psyche-soma, since in reaction to this abnormal environmental state the thinking of the individual begins to take over and organize the caring for the psyche-soma, whereas in health it is the function of the environment to do this. In health the mind does not usurp the environment's function, but makes possible an understanding and eventually a making use of its relative failure.

The gradual process whereby the individual becomes able to care for the self belongs to later stages in individual emotional development, stages that must be reached in due course, at the pace that is set by natural developmental forces.

To go a stage further, one might ask what happens if the strain that is put on mental functioning organized in defence against a tantalizing early environment is greater and greater? One would expect confusional states, and (in the extreme) mental defect of the kind that is not dependent on brain tissue deficiency. As a more common result of the lesser degrees of tantalizing infant-care in the earliest stages we find *mental functioning becoming a thing in itself*, practically replacing the good mother and making her unnecessary. Clinically, this can go along with dependence on the actual mother and a false personal growth on a compliance basis. This is a most uncomfortable state of affairs, especially because the psyche of the individual gets 'seduced' away into this mind from the intimate relationship which the psyche originally had with the soma. The result is a mind-psyche, which is pathological.

A person who is developing in this way displays a distorted pattern affecting all later stages of development. For instance, one can observe a tendency for easy identification with the environmental aspect of all relationships that involve dependence, and a difficulty in identification with the dependent individual. Clinically one may see such a person develop into one who is a *marvellously good mother to others* for a limited period; in fact a person who has developed along these lines may have almost magical *healing properties* because of an extreme capacity to make active adaptation to primitive needs. The falsity of these patterns for expression of the personality, however, becomes evident in practice. Breakdown

threatens or occurs, because what the individual is all the time needing is *to find someone else* who will make real this 'good environment' concept, so that the individual may return to the dependent psyche-soma which forms the only place to live from. In this case, 'without mind' becomes a desired state.

There cannot of course be a direct partnership between the mind-psyche and the body of the individual. But the *mind*-psyche is localized by the individual, and is placed either inside the head or outside it in some special relation to the head, and this provides an important source for headache as a symptom.

The question has to be asked why the head should be the place inside or outside which the mind becomes localized by the individual, and I do not know the answer. I feel that an important point is the individual's need to localize the mind because it is an enemy, that is to say, for control of it. A schizoid patient tells me that the head is the place to put the mind because, *as the head cannot be seen by oneself*, it does not obviously exist as part of oneself. Another point is that the head has special experiences during the birth process, but in order to make full use of this latter fact I must go on to consider another type of mental functioning which can be specially activated during the birth process. This is associated with the word 'memorizing'.

Memorizing

As I have said, the continuity of being of the developing psyche-soma (internal and external relationships) is disturbed by reactions to environmental impingements, in other words by the results of failures of the environment to make active adaptation. By my theory a rapidly increasing amount of reaction to impingement disturbing continuity of psyche-soma being becomes expected and allowed for according to mental capacity. Impingements demanding *excessive* reactions (according to the next part of my theory) cannot be allowed for. All that can happen apart from confusion is that the reactions can be *catalogued.** Typically at birth there is apt to be an excessive disturbance of continuity because of reactions to impingements, and the mental activity which I am describing at the moment is that which is concerned with exact memorizing during the birth process. In my psychoanalytic work I sometimes meet with regressions fully under control and yet going back to pre-natal life. Patients regressed in an ordered way go over the birth process again and again, and I have been astonished by the convincing proof that I have had that an infant during the birth process not only memorizes every reaction disturbing the continuity of being, but also appears to memorize these in the correct order. I have not used hypnosis, but I am aware of the comparable discoveries, less convincing to me, that are achieved through use of hypnosis. Mental functioning of the type that I am describing, which might be called memorizing or cataloguing, can be extremely active and accurate at the time of a baby's birth. I shall illustrate this by details from a case, but first I want to make clear my point that *this type of mental functioning is an encumbrance to the psyche-soma*, or of the individual human being's continuity of being which constitutes the self. The individual may be able to make use of it to relive the birth process in play or in a carefully controlled analysis. But this cataloguing type of mental functioning acts like a foreign body if it is associated with environmental adaptive failure that is beyond understanding or prediction.

No doubt in health it may happen that the environmental factors are held fixed by this method until the individual is able to make them his own after having experienced libidinous and especially aggressive drives, which can be projected. In this way, and it is essentially a false way, the individual gets to feel responsible for the bad environment which in fact he was not responsible for, and which he could (if he knew) justly blame on the world because it disturbed the continuity of his innate

* Cf. Freud's theory of obsessional neurosis.

developmental processes before the psyche-soma had become sufficiently well organized to hate or to love. Instead of hating these environmental failures the individual became disorganized by them because the process existed prior to hating.

Clinical illustration

The following fragment of a case history is given to illustrate my thesis. Out of several years' intensive work it is notoriously difficult to choose a detail; nevertheless, I include this fragment in order to show that what I am putting forward is very much a part of daily practice with patients.

A woman* who is now 47 years old had made what seemed to others but not to herself to be a good relationship to the world and had always been able to earn her own living. She had achieved a good education and was generally liked; in fact I think she was never actively disliked. She herself, however, felt completely dissatisfied, as if always aiming to find herself and never succeeding. Suicidal ideas were certainly not absent but they were kept at bay by her belief which dated from childhood that she would ultimately solve her problem and find herself. She had had a so-called 'classical' analysis for several years but somehow the core of her illness had been unchanged. With me it soon became apparent that this patient must make a very severe regression or else give up the struggle. I therefore followed the regressive tendency, letting it take the patient wherever it led; eventually the regression reached the limit of the patient's need, and from then on there has been a natural progression with the true self instead of a false self in action.

For the purpose of this paper I choose for description one thing out of an enormous amount of material. In the patient's previous analysis there had been incidents in which the patient had thrown herself off the couch in an hysterical way. These episodes had been interpreted along ordinary lines for hysterical phenomena of this kind. In the deeper regression of this new analysis light was thrown on the root of these falls. In the course of the two years of analysis with me the patient has repeatedly regressed to an early stage which was certainly prenatal. The birth process has had to be relived, and eventually I recognized how an unconscious need to relive the birth process underlay what had previously been an hysterical falling off the couch.

A great deal could be said about all this, but the important thing from my point of view here is that evidently every detail of the birth experience had been retained, and not only that, but the details had been retained in the exact sequence of the original experience. A dozen or more times the birth process was relived and each time the reaction to one of the major external features of the original birth process was singled out for re-experiencing.

Incidentally, these relivings illustrated one of the main functions of acting out; by acting out the patient informed herself of the bit of psychic reality which was difficult to get at at the moment, but of which the patient so acutely needed to become aware. I will enumerate some of the acting-out patterns, but unfortunately I cannot give the sequence which nevertheless I am quite sure was significant.

(1) The breathing changes had to be gone over in most elaborate detail.

(2) The constrictions passing down the body had to be relived and so remembered.

(3) The birth from the fantasy inside of the belly of the mother, who was a depressive, unrelaxed person.

(4) The changeover from not feeding to feeding from the breast, and from the bottle.

(5) The same with the addition that the patient had sucked her thumb in the womb and on coming out had to have the fist in relation to the breast or bottle, thus making continuity between object relationships within and without.

(6) The severe experience of pressure on the head, and also the extreme of awfulness of the release of pressure on the head; during which phase, unless her head were held, she could not have endured the re-enactment.

(7) There is much which is not yet understood in this analysis about the bladder functions affected by the birth process.

(8) The changeover from pressure all round which belongs to the intra-uterine stage to pressure from underneath which belongs to the extra-uterine state. Pressure if not excessive means love.

* Case referred to again in another paper (see Winnicott, 1954).

After birth therefore she was loved on the under side only and unless turned round periodically, became confused.

Here I must leave out perhaps a dozen other factors of comparable significance.

(9) Gradually the re-enactment reached the worst part. When we were nearly there, there was the anxiety of having the head crushed. This was first got under control by the patient's identification with the crushing mechanism. This was a dangerous phase because if acted out outside the transference situation it meant suicide. In this acting-out phase the patient existed in the crushing boulders or whatever might present, and the gratification came to her then from *destruction* of the head (including mind and false psyche) which had lost significance for the patient as part of the self.

(10) Ultimately the patient had to accept annihilation. We had already had many indications of a period of blackout or unconsciousness, and convulsive movements made it likely that there was at some time in infancy a minor fit. It appears that in the actual experience there was a loss of consciousness which could not be assimilated to the patient's self until accepted as a death. When this had become real the word death became wrong and the patient began to substitute 'a giving-in', and eventually the appropriate word was 'a not-knowing'.

In a full description of the case I should want to continue along these lines for some time, but development of this and other themes must be made in future publications. Acceptance of not-knowing produced tremendous relief. 'Knowing' became transformed into 'the analyst knows', that is to say, 'behaves reliably in active adaptation to the patient's needs'. The patient's whole life had been built up around mental functioning which had become falsely the place (in the head) from which she lived, and her life which had rightly seemed to her false had been developed out of this mental functioning.

Perhaps this clinical example illustrates what I mean when I say that I got from this analysis a feeling that the cataloguing of reactions to environmental impingements belonging to the time around about birth had been exact and complete; in fact I felt that the only alternative to the success of this cataloguing was absolute failure, hopeless confusion and mental defect.

But the case illustrates my theme in detail as well as generally.

I quote again from Scott (1949):

Similarly when a patient in analysis loses his mind in the sense that he loses the illusion of needing a psychic apparatus which is separate from all that which he has called his body, his world, etc. etc., this loss is equivalent to the gain of all that conscious access to and control of the connexions between the superficies and the depths, the boundaries and solidity of his Body Scheme—its memories, its perceptions, its images, etc., etc., which he had given up at an earlier period in his life when the duality soma-psyche began.

Not infrequently in a patient whose first complaint is of fear of 'losing his mind'—the desire to lose such a belief and obtain a better one soon becomes apparent.

At this point of not-knowing in this analysis there appeared the memory of a bird that was seen as 'quite still except for the movements of the belly which indicated breathing'. In other words, the patient had reached, at 47 years, the state in which physiological functioning in general constitutes living. The psychical elaboration of this could follow. This psychical elaboration of physiological functioning is quite different from the intellectual work which so easily becomes artificially a thing in itself and falsely a place where the psyche can lodge.

Naturally only a glimpse of this patient can be given, and even if one chooses a small part, only a bit of this part can be described. I would like, however, to pursue a little the matter of the gap in consciousness. I need not describe the gap as it appeared in more 'forward' terms, the bottom of a pit, for instance, in which in the dark were all sorts of dead and dying bodies. Just now I am concerned only with the most primitive of the ways in which the gap was found, by the patient, by the reliving processes belonging to the transference situation. The gap in continuity which had all the patient's life been something actively denied now became something urgently

sought. We found a need to have the head broken into, and violent head banging appeared as part of an attempt to produce a blackout. At times there was an urgent need for the destruction of the mental processes located by the patient in the head. A series of defences against full recognition of the desire to reach the gap in continuity of consciousness had to be dealt with before there could be acceptance of the not-knowing state. It happened that on the day on which this work reached its climax the patient stopped writing her diary.* This diary had been kept right during the analysis, and it would be possible to reconstruct the whole of her analysis up to this time from it. There is little that the patient could perceive that has not been at least indicated in this diary. The meaning of the diary now became clear—it was a projection of her mental apparatus, and not a picture of the true self, which, in fact, had never lived till, at the bottom of the regression, there came a new chance for the true self to start.

The results of this bit of work led to a temporary phase in which there was no mind and no mental functioning. There had to be a temporary phase in which the breathing of her body was all. In this way the patient became able to accept the not-knowing condition because I was holding her and keeping a continuity by my own breathing, while she let go, gave in, knew nothing; it could not be any good however, if I held her and maintained my own continuity of life if she were dead. What made my part operative was that I could see and hear her belly moving as she breathed (like the bird) and therefore I knew that she was alive.

Now for the first time she was able to have a psyche, an entity of her own, a body that breathes and in addition the beginning of fantasy belonging to the breathing and other basic physiological functions.

We as observers know, of course, that the mental functioning which enables the psyche to be there enriching the soma is dependent on the intact brain. But we do not place the psyche anywhere, not even in the brain on which it depends. For this patient, regressed in this way, these things were at last not important. I suppose she would now be prepared to locate the psyche wherever the soma is alive.

(This patient has made considerable progress since this paper was read. Now in 1954 we are able to look back on the period of the stage I have chosen for description, and to see it in perspective. I do not need to modify what I have written. Except for the violent complication of the birth process body-memories, there has been no major disturbance of the patient's regression to a certain very early stage and subsequent forward movement towards a new existence as a real individual who feels real.)

Mind localized in the head

I now leave my illustration and return to the localizing of the mind in the head. I have said that the imaginative elaboration of body parts and functions is not localized. There may, however, be localizations which are quite logical in the sense that they belong to the way in which the body functions. For instance, the body takes in and gives out substances. An inner world of personal imaginative experience therefore comes into the scheme of things, and shared reality is on the whole thought of as outside the personality. Although babies cannot draw pictures, I think that they are capable (except through lack of skill) of depicting themselves by a circle at certain moments in their first months. Perhaps if all is going well, they can achieve this soon after birth; at any rate we have good evidence that at six months a baby is at times using the circle or sphere as a diagram of the self. It is at this point that Scott's body scheme is so illuminating and especially his reminder that we are referring to time as well as to space. In the body scheme as I understand it there seems to me to be no place for the mind, and this is not a criticism of the body scheme as a diagram; it is a com-

* The diary was resumed at a later date, for a time, with a looser function, and a more positive aim including the idea of one day using her experiences profitably.

ment on the falsity of the concept of the mind as a localized phenomenon.

In trying to think out why the head is the place where either the mind is localized or else outside which it is localized, I cannot help thinking of the way in which the head of the human baby is affected during birth, the time at which the mind is furiously active cataloguing reactions to a specific environmental persecution.

Cerebral functioning tends to be localized by people in the head in popular thought, and one of the consequences of this deserves special study. Until quite recently surgeons could be persuaded to open the skulls of mentally defective infants to make possible further development of their brains which were supposed to be constricted by the bones of the skull. I suppose the early trephining of the skull was for relief of *mind* disorders, i.e. for cure of persons whose mental functioning was their enemy and who had falsely localized their mental functioning in their heads. At the present time the curious thing is that once again in medical scientific thought the brain has got equated with the mind, which is felt by a certain kind of ill person to be an enemy, and a thing in the skull. The surgeon who does a leucotomy would *at first* seem to be doing what the patient asks for, that is, to be relieving the patient of mind activity, the mind having become the enemy of the psyche-soma. Nevertheless, we can see that the surgeon is caught up in the mental patient's false localization of the mind in the head, with its sequel, the equating of mind and brain. When he has done his work he has failed in the second half of his job. The patient wants to be relieved of the *mind activity* which has become a threat to the psyche-soma, but the patient next needs the full-functioning brain tissue *in order to be able to have psyche-soma existence.* By the operation of leucotomy with its irreversible brain changes the surgeon has made this impossible. Alternatively, the procedure has been of no use except through what the operation means to the patient's unconscious.

The imaginative elaboration of somatic experience, the psyche, and for those who use the term, the soul, depends on the intact brain, as we know. We do not expect the *unconscious* of anyone to know such things, but we feel the neuro-surgeon ought to be to some extent affected by intellectual considerations.

Psychosomatic illness

In these terms we can see that one of the aims of *psychosomatic illness* is to draw the psyche from the mind back to the original intimate association with the soma. It is not sufficient to analyse the hypochondria of the psychosomatic patient, although this is an essential part of the treatment. One has also to be able to see the *positive value of the somatic disturbance* in its work of counteracting a 'seduction' of the psyche into the mind. Similarly, the aim of physiotherapists and the relaxationists can be understood in these terms. They do not have to know what they are doing to be successful psychotherapists. In one example of the application of these principles, if one tries to teach a pregnant woman how to do all the right things one not only makes her anxious, but one feeds the tendency of the psyche to lodge in the mental processes. *Per contra*, the relaxation methods at their best enable the mother to become body-conscious, and (if she is not a mental case) these methods help her to a continuity of being, and enable her to live as a psyche-soma. This is essential if she is to experience child-birth and the first stages of mothering in a natural way.

Summary

1. The true self, a continuity of being, is in health based on psyche-soma growth.

2. Mental activity is a special case of the functioning of the psyche-soma.

3. Intact brain functioning is the basis for psyche-being as well as for mental activity.

4. There is no localization of a mind self, and there is no thing that can be called mind.

5. Two distinct bases for normal mental functioning can already be given; viz.: (*a*) conversion of good enough environment

into perfect (adapted) environment, enabling minimum of reaction to impingement and maximum of natural (continuous) self-development; and (*b*) cataloguing of impingements (birth trauma, etc.) for assimilation at later stages of development.

6. It is to be noted that psyche-soma growth is universal and its complexities are inherent, whereas mental development is somewhat dependent on variable factors such as the quality of early environmental factors, the chance phenomena of birth and of management immediately after birth, etc.

7. It is logical to oppose psyche and soma and therefore to oppose the emotional development and the bodily development of an individual. It is not logical, however, to oppose the mental and the physical as these are not of the same stuff. Mental phenomena are complications of variable importance in psyche-soma continuity of being, in that which adds up to the individual's 'self'.

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