

THE MATURATIONAL
PROCESSES AND THE
FACILITATING
ENVIRONMENT

Studies in the Theory of Emotional Development

By

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in the transference a phase (or phases) of serious regression to dependence.

My experiences have led me to recognize that dependent or deeply regressed patients can teach the analyst more about early infancy than can be learned from direct observation of infants, and more than can be learned from contact with mothers who are involved with infants. At the same time, clinical contact with the normal and abnormal experiences of the infant-mother relationship influences the analyst's analytic theory since what happens in the transference (in the regressed phases of certain of his patients) is a form of infant-mother relationship.

I like to compare my position with that of Greenacre, who has also kept in touch with paediatrics while pursuing her practice of psycho-analysis. With her too it seems to be clear that each of the two experiences has influenced her in her assessment of the other experience.

Clinical experience in adult psychiatry can have the effect on a psycho-analyst of placing a gap between his assessment of a clinical state and his understanding of its aetiology. The gap derives from an impossibility of getting a reliable history of early infancy either from a psychotic patient or from the mother, or from more detached observers. Analytic patients who regress to serious dependence in the transference fill in this gap by showing their expectations and their needs in the dependent phases.

Ego-needs and Id-needs

It must be emphasized that in referring to the meeting of infant needs I am not referring to the satisfaction of instincts. In the area that I am examining the instincts are not yet clearly defined as internal to the infant. The instincts can be as much external as can a clap of thunder or a hit. The infant's ego is building up strength and in consequence is getting towards a state in which id-demands will be felt as part of the self, and not as environmental. When this development occurs, then id-satisfaction becomes a very important strengthener of the ego, or of the True Self; but id-excitements can be traumatic when the ego is not yet able to include them, and not yet able to contain the risks involved and the frustrations experienced up to the point when id-satisfaction becomes a fact.

A patient said to me: 'Good management' (ego care) 'such as I have experienced during this hour is a feed' (id-satisfaction). He could not have said this the other way round, for if I had fed him he would have complied and this would have played into

EGO DISTORTION IN TERMS OF TRUE AND FALSE SELF

(1960)

One recent development in psycho-analysis has been the increasing use of the concept of the False Self. This concept carries with it the idea of a True Self.

History

This concept is not in itself new. It appears in various guises in descriptive psychiatry and notably in certain religions and philosophical systems. Evidently a real clinical state exists which deserves study, and the concept presents psycho-analysis with an aetiological challenge. Psycho-analysis concerns itself with the questions:

- (1) How does the False Self arise?
- (2) What is its function?
- (3) Why is the False Self exaggerated or emphasized in some cases?
- (4) Why do some persons not develop a False Self system?
- (5) What are the equivalents to the False Self in normal people?
- (6) What is there that could be named a True Self?

It would appear to me that the idea of a False Self, which is an idea which our patients give us, can be discerned in the early formulations of Freud. In particular I link what I divide into a True and a False Self with Freud's division of the self into a part that is central and powered by the instincts (or by what Freud called sexuality, pregenital and genital), and a part that is turned outwards and is related to the world.

Personal Contribution

My own contribution to this subject derives from my working at one and the same time

- (a) as a paediatrician with mothers and infants and
- (b) as a psycho-analyst whose practice includes a small series of borderline cases treated by analysis, but needing to experience

his False Self defence, or else he would have reacted and rejected my advances, maintaining his integrity by choosing frustration.

Other influences have been important for me, as for instance when periodically I have been asked for a note on a patient who is now under psychiatric care as an adult but who was observed by myself when an infant or small child. Often from my notes I have been able to see that the psychiatric state that now exists was already to be discerned in the infant-mother relationship. (I leave out infant-father relationships in this context because I am referring to early phenomena, those that concern the infant's relationship to the mother, or to the father as another mother. The father at this very early stage has not become significant as a male person.)

Example

The best example I can give is that of a middle-aged woman who had a very successful False Self but who had the feeling all her life that she had not started to exist, and that she had always been looking for a means of getting to her True Self. She still continues with her analysis, which has lasted many years. In the first phase of this research analysis (this lasted two or three years), I found I was dealing with what the patient called her 'Caretaker Self'. This 'Caretaker Self':

- (1) found psycho-analysis;
- (2) came and sampled analysis, as a kind of elaborate test of the analyst's reliability;
- (3) brought her to analysis;
- (4) gradually after three years or more handed over its function to the analyst
(this was the time of the depth of the regression, with a few weeks of a very high degree of dependence on the analyst);
- (5) hovered round, resuming caretaking at times when the analyst failed (analyst's illness, analyst's holidays, etc.);
- (6) its ultimate fate will be discussed later.

From the evolution of this case it was easy for me to see the defensive nature of the False Self. Its defensive function is to hide and protect the True Self, whatever that may be. Immediately it becomes possible to classify False Self organizations:

- (1) At one extreme: the False Self sets up as real and it is this that observers tend to think is the real person. In living relationships, work relationships, and friendships, however, the False Self begins to fail. In situations in which what is

expected is a whole person the False Self has some essential lacking. At this extreme the True Self is hidden.

- (2) Less extreme: the False Self defends the True Self; the True Self is, however, acknowledged as a potential and is allowed a secret life. Here 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. This is an extension of the psycho-analytic concept of the value of symptoms to the sick person.
- (3) More towards health: The False Self has as its main concern a search for conditions which will make it possible for the True Self to come into its own. If conditions cannot be found then there must be reorganized a new defence against exploitation of the True Self, and if there be doubt then the clinical result is suicide. Suicide in this context is the destruction of the total self in avoidance of annihilation of the True Self. When suicide is the only defence left against betrayal of the True Self, then it becomes the lot of the False Self to organize the suicide. This, of course, involves its own destruction, but at the same time eliminates the need for its continued existence, since its function is the protection of the True Self from insult.
- (4) Still further towards health: the False Self is built on identifications (as for example that of the patient mentioned, whose childhood environment and whose actual nannie gave much colour to the False Self organization).
- (5) In health: the False Self is represented by the whole organization of the polite and mannered social attitude, a 'not wearing the heart on the sleeve', as might be said. Much has gone to the individual's ability to forgo omnipotence and the primary process in general, the gain being the place in society which can never be attained or maintained by the True Self alone.

So far I have kept within the bounds of clinical description. Even in this limited area recognition of the False Self is important, however. For instance, it is important that patients who are essentially False Personalities shall not be referred to students of psycho-analysis for analysis under a training scheme. The diagnosis of False Personality is here more important than the diagnosis of the patient according to accepted psychiatric classifications. Also in social work, where all types of case must be accepted and kept in treatment, this diagnosis of False Personality is important in the avoidance of extreme frustration associated

with therapeutic failure in spite of seemingly sound social work based on analytic principles. Especially is this diagnosis important in the *selection* of students for training in psycho-analysis or in psychiatric social work, that is to say, in the selection of case-work students of all kinds. The organized False Self is associated with a rigidity of defences which prevents growth during the student period.

The Mind and the False Self

A particular danger arises out of the not infrequent tie-up between the intellectual approach and the False Self. When a False Self becomes organized in an individual who has a high intellectual potential there is a very strong tendency for the mind to become the location of the False Self, and in this case there develops a dissociation between intellectual activity and psychosomatic existence. (In the healthy individual, it must be assumed, the mind is not something for the individual to exploit in escape from psycho-somatic being. I have developed this theme at some length in 'Mind and its Relation to the Psyche-Soma', 1949c.)

When there has taken place this double abnormality, (i) the False Self organized to hide the True Self, and (ii) an attempt on the part of the individual to solve the personal problem by the use of a fine intellect, a clinical picture results which is peculiar in that it very easily deceives. The world may observe academic success of a high degree, and may find it hard to believe in the very real distress of the individual concerned, who feels 'phoney' the more he or she is successful. When such individuals destroy themselves in one way or another, instead of fulfilling promise, this invariably produces a sense of shock in those who have developed high hopes of the individual.

Aetiology

The main way in which these concepts become of interest to psycho-analysts derives from a study of the way a False Self develops at the beginning, in the infant-mother relationship, and (more important) the way in which a False Self does not become a significant feature in normal development.

The theory relative to this important stage in ontogenetic development belongs to the observation of infant-to-mother (regressed patient-to-analyst) living, and it does not belong to the theory of early mechanisms of ego-defence organized against id-impulse, though of course these two subjects overlap.

To get to a statement of the relevant developmental process it is essential to take into account the mother's behaviour and atti-

tude, because in this field dependence is real, and near absolute. *It is not possible to state what takes place by reference to the infant alone.*

In seeking the aetiology of the False Self we are examining the stage of first object-relationships. At this stage the infant is most of the time unintegrated, and never fully integrated; cohesion of the various sensori-motor elements belongs to the fact that the mother holds the infant, sometimes physically, and all the time figuratively. Periodically the infant's gesture gives expression to a spontaneous impulse; the source of the gesture is the True Self, and the gesture indicates the existence of a potential True Self. We need to examine the way the mother meets this infantile omnipotence revealed in a gesture (or a sensori-motor grouping). I have here linked the idea of a True Self with the spontaneous gesture. Fusion of the motility and erotic elements is in process of becoming a fact at this period of development of the individual.

The Mother's Part

It is necessary to examine the part played by the mother, and in doing so I find it convenient to compare two extremes; by one extreme the mother *is a good-enough mother* and by the other the mother *is not a good-enough mother*. The question will be asked: what is meant by the term 'good-enough'?

The good-enough mother meets the omnipotence of the infant and to some extent makes sense of it. She does this repeatedly. A True Self begins to have life, through the strength given to the infant's weak ego by the mother's implementation of the infant's omnipotent expressions.

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.

It is an essential part of my theory that the True Self does not become a living reality except as a result of the mother's repeated success in meeting the infant's spontaneous gesture or sensory hallucination. (This idea is closely linked with Sechchaye's idea contained in the term 'symbolic realization'. This term has played an important part in modern psycho-analytic theory, but it is not quite accurate since it is the infant's *gesture or hallucination* that is made real, and the capacity of the infant *to use a symbol* is the result.)

There are now two possible lines of development in the scheme

of events according to my formulation. *In the first case* the mother's adaptation is *good enough* and in consequence the infant begins to believe in external reality which appears and behaves as by magic (because of the mother's relatively successful adaptation to the infant's gestures and needs), and which acts in a way that does not clash with the infant's omnipotence. On this basis the infant can gradually abrogate omnipotence. The True Self has a spontaneity, and this has been joined up with the world's events. The infant can now begin to enjoy the *illusion* of omnipotent creating and controlling, and then can gradually come to recognize the illusory element, the fact of playing and imagining. Here is the basis for the symbol which at first is *both* the infant's spontaneity or hallucination, *and also* the external object created and ultimately cathected.

In between the infant and the object is some thing, or some activity or sensation. In so far as this joins the infant to the object (viz. maternal part-object) so far is this the basis of symbol-formation. On the other hand, in so far as this something separates instead of joins, so is its function of leading on to symbol-formation blocked.

In the second case, which belongs more particularly to the subject under discussion, the mother's adaptation to the infant's hallucinations and spontaneous impulses is deficient, *not good enough*. The process that leads to the capacity for symbol-usage does not get started (or else it becomes broken up, with a corresponding withdrawal on the part of the infant from advantages gained).

When the mother's adaptation is not good enough at the start the infant might be expected to die physically, because cathexis of external objects is not initiated. The infant remains isolated. But in practice the infant lives, but lives falsely. The protest against being forced into a false existence can be detected from the earliest stages. The clinical picture is one of general irritability, and of feeding and other function disturbances which may, however, disappear clinically, only to reappear in serious form at a later stage.

In this second case, where the mother cannot adapt well enough, the infant gets seduced into a compliance, and a compliant False Self reacts to environmental demands and the infant seems to accept them. 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.

In the extreme examples of False Self development, the True Self is so well hidden that spontaneity is not a feature in the infant's living experiences. Compliance is then the main feature, with imitation as a speciality. When the degree of the split in the infant's person is not too great there may be some almost personal living through imitation, and it may even be possible for the child to act a special role, that of the True Self *as it would be if it had had existence*.

In this way it is possible to trace the point of origin of the False Self, which can now be seen to be a defence, a defence against that which is unthinkable, the exploitation of the True Self, which would result in its annihilation. (If the True Self ever gets exploited and annihilated this belongs to the life of an infant whose mother was not only 'not good enough' in the sense set out above, but was good and bad in a tantalizingly irregular manner. The mother here has as part of her illness a need to cause and to maintain a muddle in those who are in contact with her. This may appear in a transference situation in which the patient tries to make the analyst mad (Bion, 1959; Searles, 1959). There may be a degree of this which can destroy the last vestiges of an infant's capacity to defend the True Self.)

I have attempted to develop the theme of the part the mother plays in my paper on 'Primary Maternal Preoccupation' (1956a). The assumption made by me in this paper is that, in health, the mother who becomes pregnant gradually achieves a high degree of identification with her infant. This develops during the pregnancy, is at its height at the time of lying in, and it gradually ceases in the weeks and months after the confinement. This healthy thing that happens to mothers has both hypochondriacal and secondary narcissistic implications. This special orientation on the part of the mother to her infant not only depends on her own mental health, but also it is affected by the environment. In the simplest case the man, supported by a social attitude which is itself a development from the man's natural function, deals with external reality for the woman, and so makes it safe and sensible for her to be temporarily in-turned, self-centred. A diagram of this resembles the diagram of an ill paranoid person or family. (One is reminded here of Freud's (1920) description of the living vesicle with its receptive cortical layer. . . .)

The development of this theme does not belong here, but it is important that the function of the mother should be understood. This function is by no means a recent development, belonging to

civilization or to sophistication or to intellectual understanding. No theory is acceptable that does not allow for the fact that mothers have always performed this essential function well enough. This essential maternal function enables the mother to know about her infant's earliest expectations and needs, and makes her personally satisfied in so far as the infant is at ease. It is because of this identification with her infant that she knows how to hold her infant, so that the infant starts by existing and not by reacting. Here is the origin of the True Self which cannot become a reality without the mother's specialized relationship, one which might be described by a common word: devotion.¹

The True Self

The concept of 'A False Self' needs to be balanced by a formulation of that which could properly be called the True Self. At the earliest stage the True Self is the theoretical position from which come the spontaneous gesture and the personal idea. The spontaneous gesture is the True Self in action. Only the True Self can be creative and only the True Self can feel real. Whereas a True Self feels real, the existence of a False Self results in a feeling unreal or a sense of futility.

The False Self, if successful in its function, hides the True Self, or else finds a way of enabling the True Self to start to live. Such an outcome may be achieved by all manner of means, but we observe most closely those instances in which the sense of things being real or worth while arrives during a treatment. My patient to whose case I have referred has come near the end of a long analysis *to the beginning of her life*. She contains no true experience, she has no past. She starts with fifty years of wasted life, but at last she feels real, and therefore she now wants to live.

The True Self comes from the aliveness of the body tissues and the working of body-functions, including the heart's action and breathing. It is closely linked with the idea of the Primary Process, and is, at the beginning, essentially not reactive to external stimuli, but primary. There is but little point in formulating a True Self idea except for the purpose of trying to understand the False Self, because it does no more than collect together the details of the experience of aliveness.

Gradually the degree of sophistication of the infant becomes such that it is more true to say that the False Self hides the infant's inner reality than to say that it hides the True Self. By this time the infant has an established limiting membrane, has an inside

¹ On account of this I called my series of talks to mothers, 'The Ordinary Devoted Mother and Her Baby' (Winnicott, 1949a).

and an outside, and has become to a considerable extent disentangled from maternal care.

It is important to note that according to the theory being formulated here the concept of an individual inner reality of objects applies to a stage later than does the concept of what is being termed the True Self. The True Self appears as soon as there is any mental organization of the individual at all, and it means little more than the summation of sensori-motor aliveness.

The True Self quickly develops complexity, and relates to external reality by natural processes, by such processes as develop in the individual infant in the course of time. The infant then comes to be able to react to a stimulus without trauma because the stimulus has a counterpart in the individual's inner, psychic reality. The infant then accounts for all stimuli as projections, but this is a stage that is not necessarily achieved, or that is only partially achieved, or it may be reached and lost. This stage having been achieved, the infant is now able to retain the sense of omnipotence even when reacting to environmental factors that the observer can discern as truly external to the infant. All this precedes by years the infant's capacity to allow in intellectual reasoning for the operation of pure chance.

Every new period of living in which the True Self has not been seriously interrupted results in a strengthening of the sense of being real, and with this goes a growing capacity on the part of the infant to tolerate two sets of phenomena: These are:

- (1) Breaks in continuity of True Self living. (Here can be seen a way in which the birth process might be traumatic, as for instance when there is delay without unconsciousness.)
- (2) Reactive or False Self experiences, related to the environment on a basis of compliance. This becomes the part of the infant which can be (before the first birthday) taught to say 'Ta', or, in other words, can be taught to acknowledge the existence of an environment that is becoming intellectually accepted. Feelings of gratitude may or may not follow.

The Normal Equivalent of the False Self

In this way, by natural processes, the infant develops an ego-organization that is adapted to the environment; but this does not happen automatically and indeed it can only happen if first the True Self (as I call it) has become a living reality, because of the mother's good-enough adaptation to the infant's living needs. There is a compliant aspect to the True Self in healthy living, an ability of the infant to comply and not to be exposed. The ability

to compromise is an achievement. The equivalent of the False Self in normal development is that which can develop in the child into a social manner, something which is adaptable. In health this social manner represents a compromise. At the same time, in health, the compromise ceases to become allowable when the issues become crucial. When this happens the True Self is able to override the compliant self. Clinically this constitutes a recurring problem of adolescence.

Degrees of False Self

If the description of these two extremes and their aetiology is accepted it is not difficult for us to allow in our clinical work for the existence of a low or a high degree of the False Self defence, ranging from the healthy polite aspect of the self to the truly split-off compliant False Self which is mistaken for the whole child. It can easily be seen that sometimes this False Self defence can form the basis for a kind of sublimation, as when a child grows up to be an actor. In regard to actors, there are those who can be themselves and who also can act, whereas there are others who can only act, and who are completely at a loss when not in a role, and when not being appreciated or applauded (acknowledged as existing).

In the healthy individual who has a compliant aspect of the self but who exists and who is a creative and spontaneous being, there is at the same time a capacity for the use of symbols. In other words health here is closely bound up with the capacity of the individual to live in an area that is intermediate between the dream and the reality, that which is called the cultural life. (See 'Transitional Objects and Transitional Phenomena', 1951.) By contrast, where there is a high degree of split between the True Self and the False Self which hides the True Self, there is found a poor capacity for using symbols, and a poverty of cultural living. 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.

Clinical Application

Reference has already been made to the importance of a recognition of the False Self personality when a diagnosis is being made for the purposes of the assessment of a case for treatment, or the assessment of a candidate for psychiatric or social psychiatric work.

Consequences for the Psycho-Analyst

If these considerations prove to have value, then the practising psycho-analyst must be affected in the following ways:

- (a) In analysis of a False Personality the fact must be recognized that the analyst can only talk to the False Self of the patient about the patient's True Self. It is as if a nurse brings a child, and at first the analyst discusses the child's problem, and the child is not directly contacted. Analysis does not start until the nurse has left the child with the analyst, and the child has become able to remain alone with the analyst and has started to play.
- (b) At the point of transition, when the analyst begins to get into contact with the patient's True Self, there must be a period of extreme dependence. Often this is missed in analytic practice. The patient has an illness, or in some other way gives the analyst a chance to take over the False Self (nursemaid) function, but the analyst at that point fails to see what is happening, and in consequence it is others who care for the patient and on whom the patient becomes dependent in a period of disguised regression to dependence, and the opportunity is missed.
- (c) Analysts who are not prepared to go and meet the heavy needs of patients who become dependent in this way must be careful so to choose their cases that they do not include False Self types.

In psycho-analytic work it is possible to see analyses going on indefinitely because they are done on the basis of work with the False Self. In one case, a man patient who had had a considerable amount of analysis before coming to me, my work really started with him when I made it clear to him that I recognized his non-existence. He made the remark that over the years all the good work done with him had been futile because it had been done on the basis that he existed, whereas he had only existed falsely. When I had said that I recognized his non-existence he felt that he had been communicated with for the first time. What he meant was that his True Self that had been hidden away from infancy had now been in communication with his analyst in the only way which was not dangerous. This is typical of the way in which this concept affects psycho-analytic work.

I have referred to some other aspects of this clinical problem. For instance, in 'Withdrawal and Regression' (1954a) I traced in the treatment of a man the evolution in the transference of my

contact with (his version of) a False Self, through my first contact with his True Self, to an analysis of a straightforward kind. In this case withdrawal had to be converted into regression as described in the paper.

A principle might be enunciated, that in the False Self area of our analytic practice we find we make more headway by recognition of the patient's non-existence than by a long-continued working with the patient on the basis of ego-defence mechanisms. The patient's False Self can collaborate indefinitely with the analyst in the analysis of defences, being so to speak on the analyst's side in the game. This unrewarding work is only cut short profitably when the analyst can point to and specify an absence of some essential feature: 'You have no mouth', 'You have not started to exist yet', 'Physically you are a man, but you do not know from experience anything about masculinity', and so on. These recognitions of important fact, made clear at the right moments, pave the way for communication with the True Self. A patient who had had much futile analysis on the basis of a False Self, co-operating vigorously with an analyst who thought this was his whole self, said to me: 'The only time I felt hope was when you told me that you could see no hope, and you continued with the analysis.'

On the basis of this one could say that the False Self (like the multiple projections at later stages of development) deceives the analyst if the latter fails to notice that, regarded as a whole functioning person, the False Self, however well set up, lacks something, and that something is the essential central element of creative originality.

Many other aspects of the application of this concept will be described in the course of time, and it may be that in some ways the concept itself will need to be modified. My object in giving an account of this part of my work (which links with the work of other analysts) is that I hold the view that this modern concept of the False Self hiding the True Self *along with the theory of its aetiology* is able to have an important effect on psycho-analytic work. As far as I can see it involves no important change in basic theory.

STRING: A TECHNIQUE OF COMMUNICATION¹

(1960)

A boy aged seven years was brought to the Psychology Department of the Paddington Green Children's Hospital by his mother and father in March 1955. The other two members of the family also came: an M.D. girl aged ten, attending an E.S.N. school, and a rather normal small girl aged four. The case was referred by the family doctor because of a series of symptoms indicating a character disorder in the boy. For the purposes of this description all details that are not immediately relevant to the main theme of this paper are omitted. An intelligence test gave this boy an I.Q. of 108.

I first saw the parents in a long interview in which they gave a clear picture of the boy's development and of the distortions in his development. They left out one important detail, however, which emerged in the interview with the boy.

It was not difficult to see that the mother was a depressive person, and she reported that she had been hospitalized on account of depression. From the parents' account I was able to note that the mother cared for the boy until the sister was born when he was 3 years 3 months. This was the first separation of importance, the next being at 3 years 11 months when the mother had an operation. When the boy was 4 years 9 months the mother went into a mental hospital for two months, and during this time he was well cared for by his mother's sister. By this time everyone looking after this boy agreed that he was difficult, although showing very good features. He was liable to change suddenly and to frighten people by saying, for instance, that he would cut his mother's sister into little pieces. He developed many curious symptoms such as a compulsion to lick things and people; he made compulsive throat noises; often he refused to pass a motion and then made a mess. He was obviously anxious about his elder sister's mental defect, but the distortion of his development appears to have started before this factor became significant.

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