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### CHAPTER

## 8 The Antisocial Tendency

Donald W. Winnicott

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### Abstract

For Winnicott the antisocial tendency in the human being is different from delinquency. He considers that the antisocial tendency may be found at all ages and stages in childhood. A child may become a *deprived child* when deprived of essential features of home life. Lack of hope is then a basic feature, but the antisocial act is an expression of that hope, and needs to be thought of in this way in treatment. The child who steals, for example, is not looking for *the object stolen but the mother over whom he or she has rights*. These rights derive from the fact that (from the child's point of view) the mother was created by the child. It is therefore a picture of the child's unconscious omnipotence and control over the mother that has led to the stealing of the object. The child's greediness, manifest in stealing, is part of the early infant self's compulsion to seek for a cure from the mother who caused the initial deprivation. At the basis of the antisocial tendency is a good early experience that has been lost.

**Keywords:** delinquency, Winnicott, antisocial tendency, mothering, stealing, object, love, hope, early deprivation, omnipotent control

**Subject:** Clinical Psychology, Clinical Child and Adolescent Psychology

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Read before the British Psychoanalytical Society, 20 June 1956.

The antisocial tendency provides psychoanalysis with some awkward problems, problems of a practical as well as a theoretical nature. Freud, through his introduction to Aichhorn's *Wayward Youth*, showed that psychoanalysis not only contributes to the understanding of delinquency, but it is also enriched by an understanding of the work of those who cope with delinquents.

I have chosen to discuss the antisocial tendency, not delinquency. The reason is that the organized antisocial defence is overloaded with secondary gain and social reactions which make it difficult for the investigator to get to its core. By contrast the antisocial tendency can be studied as it appears in the normal or near-normal child, where it is related to the difficulties that are inherent in emotional development.

I will start with two simple references to clinical material:

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For my first child analysis I chose a delinquent. This boy attended regularly for a year and the treatment stopped because of the disturbance that the boy caused in the clinic. I could say that the analysis was going well, and its cessation caused distress both to the boy and to myself in spite of the fact that on several occasions I got badly bitten on the buttocks. The boy got out on the roof and also he spilt so much water that the basement became flooded. He broke into my locked car and drove it away in bottom gear on the self-starter. The clinic ordered termination of the treatment for the sake of the other patients. He went to an approved school.

↳ I may say that he is now 35, and he has been able to earn his living in a job that caters for his restlessness. He is married, with several children. Nevertheless I am afraid to follow up his case for fear that I should become involved again with a psychopath, and I prefer that society should continue to take the burden of his management.

It can easily be seen that the treatment for this boy should have been not psychoanalysis but placement. Psychoanalysis only made sense if added after placement. Since this time I have watched analysts of all kinds fail in the psychoanalysis of antisocial children.

By contrast, the following story brings out the fact that an antisocial tendency may sometimes be treated very easily if the treatment be adjunctive to specialized environmental care.

I was asked by a friend to discuss the case of her son, the eldest of a family of four. She could not bring John to me in an open way because of her husband who objects to psychology on religious grounds. All she could do was to have a talk with me about the boy's compulsion to steal, which was developing into something quite serious; he was stealing in a big way from shops as well as at home. It was not possible for practical reasons to arrange for anything else but for the mother and myself to have a quick meal together in a restaurant, in the course of which she told me about the troubles and asked me for advice. There was nothing for me to do unless I could do it then and there. I therefore explained the meaning of the stealing and suggested that she should find a good moment in her relationship with the boy and make an interpretation to him. It appeared that she and John had a good relationship with each other for a few moments each evening after he had gone to bed; usually at such a time he would discuss the stars and the moon. This moment could be used.

I said: 'Why not tell him that you know that when he steals he is not wanting the things that he steals but he is looking for something that he has a right to: that he is making a claim on his mother and father because he feels deprived of their love'. I told her to use language which he could understand. I may say that I knew enough of this family, in which both the parents are musicians, to see how it was that this boy had become to some extent a deprived child, although he has a good home.

Some time later I had a letter telling me that she had done what I suggested. She wrote: 'I told him that what he really wanted when he stole money and food and things was his mum; and I must say I didn't really expect him to understand, but he did seem to. I asked him if he thought we didn't love him because he was so naughty sometimes, and he said right out that he didn't think we did, much. Poor little scrap! I felt so awful, I can't tell you. So I told him never, never to doubt it again

and if he ever did feel doubtful to remind me to tell him again. But of course I shan't need reminding for a long time, it's been such a shock. One seems to need these shocks. So I'm being a lot more demonstrative to try and keep him from being doubtful any more. And up to now there's been absolutely no more stealing'.

The mother had had a talk with the form teacher and had explained to her that the boy was in need of love and appreciation, and had gained her co-operation although the boy gives a lot of trouble at school.

Now after eight months it is possible to report that there has been no return of stealing, and the relationship between the boy and his family has very much improved.

In considering this case it must be remembered that I had known the mother very well during her adolescence and to some extent had seen her through an antisocial phase of her own. She was the eldest in a large family. She had a very good home but very strong discipline was exerted by the father, especially at the time when she was a small child. What I did therefore had the effect of a double therapy, enabling this young woman to get insight into her own difficulties through the help that she was able to give to her son. When we are able to help parents to help their children we do in fact help them about themselves.

(In another paper I propose to give clinical examples illustrating the management of children with antisocial tendency; here I do no more than attempt a brief statement of the basis of my personal attitude to the clinical problem.)

## Nature of Antisocial Tendency

The antisocial tendency is *not a diagnosis*. It does not compare directly with other diagnostic terms such as neurosis and psychosis. The antisocial tendency may be found in a normal individual, or in one that is neurotic or psychotic.

For the sake of simplicity I will refer only to children, but the antisocial tendency may be found at all ages. The various terms in use in Great Britain may be brought together in the following way:

A child becomes a *deprived child* when deprived of certain essential features of home life. Some degree of what might be called the 'deprived complex' becomes manifest. *Antisocial behaviour* will be manifest at home or in a wider sphere. On account of *the antisocial tendency* the child may eventually need to be *deemed maladjusted*, and to receive treatment in a *hostel for maladjusted children*, or may be brought before the courts as *beyond control*. The child, now a *delinquent*, may then become a *probationer* under a court order, or may be sent to an *approved school*. If the home ceases to function in an important respect the child may be taken over by the Children's Committee (under the Children Act, 1948) and be given '*care and protection*'. If possible a foster home will be found. Should these measures fail the young adult may be said to have become a *psychopath* and may be sent by the courts to a *Borstal* or to prison. There may be an established tendency to repeat crimes for which we use the term *recidivism*.

All this makes no comment on the individual's psychiatric diagnosis.

The antisocial tendency is characterized by an *element in it which compels the environment to be important*. The patient through unconscious drives compels someone to attend to management. It is the task of the therapist to become involved in this the patient's unconscious drive, and the work is done by the therapist in terms of management, tolerance, and understanding.

*The antisocial tendency implies hope.* Lack of hope is the basic feature of the deprived child who, of course, is not all the time being antisocial. In the period of hope the child manifests an antisocial tendency. This may be awkward for society, and for you if it is your bicycle that is stolen, but those who are not personally involved can see the hope that underlies the compulsion to steal. Perhaps one of the reasons why we tend to leave the therapy of the delinquent to others is that we dislike being stolen from?

The understanding that the antisocial act is an expression of hope is vital in the treatment of children who show the antisocial tendency. Over and over again one sees the moment of hope wasted, or withered, because of mismanagement or intolerance. This is another way of saying that the treatment of the antisocial tendency is not psychoanalysis but management, a going to meet and match the moment of hope.

There is a direct relationship between the antisocial tendency and deprivation. This has long been known by specialists in the field, but it is largely due to John Bowlby that there is now a widespread recognition of the relationship that exists between the antisocial tendency in individuals and emotional deprivation, typically in the period of late infancy and the early toddler stage, round about the age of one and two years.

When there is an antisocial tendency *there has been a true deprivation* (not a simple privation); that is to say, there has been a loss of something good that has been positive in the child's experience up to a certain date,<sup>1</sup> and that has been withdrawn; the withdrawal has extended over a period of time longer than that over which the child can keep the memory of the experience alive. The comprehensive statement of deprivation is one that includes both the early and the late, both the pinpoint trauma and the sustained traumatic condition and also both the near normal and the clearly abnormal.

## Note

p. 153 In a statement in my own language of Klein's depressive position (The Depressive Position in Normal Emotional Development [CW 4:3:5]), I have tried to make clear the intimate relationship that exists between Klein's concept and Bowlby's emphasis on deprivation. Bowlby's three stages of the clinical reaction of a child of two years who goes to hospital can be given a theoretical formulation in terms of the gradual loss of hope because of the death of the internal object or introjected version of the external object that is lost. What can be further discussed is the relative importance of death of the internal object through anger and contact of 'good objects' with hate products within the psyche, and ego maturity or immaturity in so far as this affects the capacity to keep alive a memory.

Bowlby needs Klein's intricate statement that is built round the understanding of melancholia, and that derives from Freud and Abraham, but it is also true that psychoanalysis needs Bowlby's emphasis on deprivation, if psychoanalysis is ever to come to terms with this special subject of the antisocial tendency.

There are always two trends in the antisocial tendency although the accent is sometimes more on one than on the other. One trend is represented typically in stealing, and the other in destructiveness. By *one* trend the child is looking for something, somewhere, and failing to find it seeks it elsewhere, when hopeful. By the *other* the child is seeking that amount of environmental stability which will stand the strain resulting from impulsive behaviour. This is a search for an environmental provision that has been lost, a human attitude which, because it can be relied on, gives freedom to the individual to move and to act and to get excited.

It is particularly because of the second of these trends that the child provokes total environmental reactions, as if seeking an ever-widening frame, a circle which had as its first example the mother's arms or the mother's body. One can discern a series—the mother's body, the mother's arms, the parental relationship, the home, the family including cousins and near relations, the school, the locality with its police-stations, the country with its laws.

In examining the near-normal and (in terms of individual development) the early roots of the antisocial tendency I wish to keep in mind all the time these two trends: object-seeking and destruction.

## Stealing

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Stealing is at the centre of the antisocial tendency, with the associated lying.

The child who steals an object is not looking for *the object stolen but seeks the mother over whom he or she has rights*. These rights derive from the fact that (from the child's point of view) the mother was created by the child. The mother met the child's primary creativity, and so became the object that the child was ready to find. (The child could not have created the mother; also the mother's meaning for the child depends on the child's creativity.)

p. 154 Is it possible to join up the two trends, the stealing and the destruction, the object-seeking and that which provokes, the libidinal and the aggressive compulsions? I suggest that the union of the two trends is in the child and that it represents *a tendency towards self-cure*, cure of a de-fusion of instincts.

When there is at the time of the original deprivation some fusion of aggressive (or motility) roots with the libidinal the child claims the mother by a mixture of stealing and hurting and messing, according to the specific details of that child's emotional developmental state. When there is less fusion the child's object-seeking and aggression are more separated off from each other, and there is a greater degree of dissociation in the child. This leads to the proposition that *the nuisance value of the antisocial child is an essential feature*, and is also, at its best, *a favourable feature* indicating again a potentiality for recovery of lost fusion of the libidinal and motility drives.

In ordinary infant care the mother is constantly dealing with the nuisance value of her infant. For instance, a baby commonly passes water on the mother's lap while feeding at the breast. At a later date this appears as a momentary regression in sleep or at the moment of waking and bed-wetting results. Any exaggeration of the nuisance value of an infant may indicate the existence of a degree of deprivation and antisocial tendency.

The manifestation of the antisocial tendency includes stealing and lying, incontinence and the making of a mess generally. Although each symptom has its specific meaning and value, the common factor for my purpose in my attempt to describe the antisocial tendency is *the nuisance value of the symptoms*. This nuisance value is exploited by the child, and is not a chance affair. Much of the motivation is unconscious, but not necessarily all.

## First Signs of Antisocial Tendency

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I suggest that the first signs of deprivation are so common that they pass for normal; take for example the imperious behaviour which most parents meet with a mixture of submission and reaction. *This is not infantile omnipotence*, which is a matter of psychic reality, not of behaviour.

A very common antisocial symptom is greediness, with the closely related inhibition of appetite. If we study greediness we shall find the deprived complex. In other words, if an infant is greedy there is some degree of deprivation and some compulsion towards seeking for a therapy in respect of this deprivation through the environment. The fact that the mother is herself willing to cater for the infant's greediness makes for therapeutic success in the vast majority of cases in which this compulsion can be observed. Greediness in an infant is not the same as greed. The word greed is used in the theoretical statement of the tremendous

p. 155 instinctual claims than an infant makes on the mother at the beginning, that is to say, at the time when the infant is only starting to allow the mother a separate existence, at the first acceptance of the Reality Principle.

In parenthesis, it is sometimes said that a mother must fail in her adaptation to her infant's needs. Is this not a mistaken idea based on a consideration of id needs and a neglect of the needs of the ego? A mother must fail in satisfying instinctual demands, but she may completely succeed in not 'letting the infant down', *in catering for ego needs*, until such a time as the infant may have an introjected ego-supportive mother, and may be old enough to maintain this introjection in spite of failures of ego support in the actual environment.

The (pre-ruth) primitive love impulse is not the same as ruthless greediness. In the process of the development of an infant the primitive love impulse and greediness are separated by the mother's adaptation. The mother necessarily fails to maintain a high degree of adaptation to id needs and to some extent therefore every infant may be deprived, but is able to get the mother to cure this sub-deprived state by her meeting the greediness and messiness, etc., these being symptoms of deprivation. The greediness is part of the infant's compulsion to seek for a cure from the mother who caused the deprivation. This greediness is antisocial; it is the precursor of stealing, and it can be met and cured by the mother's therapeutic adaptation, so easily mistaken for spoiling. It should be said, however, that whatever the mother does, this does not annul the fact that the mother first failed in her adaptation to her infant's ego needs. The mother is usually able to meet the compulsive claims of the infant, and so to do a successful *therapy* of the deprived complex which is near its point of origin. She gets near to a cure because she enables the infant's hate to be expressed while she, the therapist, is in fact the depriving mother.

It will be noted that whereas the infant is under no obligation to the mother in respect of her meeting the primitive love impulse, there is some feeling of obligation as the result of the mother's therapy, that is to say her willingness to meet the claims arising out of frustration, claims that begin to have a nuisance value. Therapy by the mother may cure, but this is not mother-love.

This way of looking at the mother's indulgence of her infant involves a more complex statement of mothering than is usually acceptable. Mother-love is often thought of in terms of this indulgence, which in fact is a *therapy in respect of a failure of mother-love*. It is a therapy, a second chance given to mothers who cannot always be expected to succeed in their initial most delicate task of primary love. If a mother does this therapy as a reaction formation arising out of her own complexes, then what she does is called spoiling. In so far as she is able to do it because she sees the necessity for the child's claims to be met, and for the child's compulsive greediness to be indulged, then it is a therapy that is usually successful. Not only the mother, but the father, and indeed the family, may be involved.

p. 156 Clinically, there is an awkward borderline between the mother's therapy which is successful and that which is unsuccessful. Often we watch a mother spoiling an infant and yet this therapy will not be successful, the initial deprivation having been too severe for mending 'by first intention' (to borrow a term from the surgery of wounds).

Just as greediness may be a manifestation of the reaction to deprivation and of an antisocial tendency, so may messiness and wetting and compulsive destructiveness. All these manifestations are closely interrelated. In bed-wetting, which is so common a complaint, the accent is on regression at the moment of the dream, or on the antisocial compulsion to claim the right to wet on mother's body.

In a more complete study of stealing I would need to refer to the compulsion to go out and buy something, which is a common manifestation of the antisocial tendency that we meet in our psychoanalytic patients. It is possible to do a long and interesting analysis of a patient without affecting this sort of symptom, which belongs not to the patient's neurotic or psychotic defences but which does belong to the antisocial tendency, that which is a reaction to deprivation of a special kind and that took place at a special time. From this it will

be clear that birthday presents and pocket money absorb some of the antisocial tendency that is to be normally expected.

In the same category as the shopping expedition we find, clinically, a 'going out', without aim, *truancy*, a centrifugal tendency that replaces the centripetal gesture which is implicit in thieving.

## The Original Loss

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There is one special point that I wish to make. At the basis of the antisocial tendency is a good early experience that has been lost. Surely, *it is an essential feature that the infant has reached to a capacity to perceive that the cause of the disaster lies in an environmental failure*. Correct knowledge that the cause of the depression or disintegration is an external one, and not an internal one, is responsible for the personality distortion and for the urge to seek for a cure by new environmental provision. The state of ego maturity enabling perception of this kind determines the development of an antisocial tendency instead of a psychotic illness. A great number of antisocial compulsions present and become successfully treated in the early stages by the parents. Antisocial children, however, are constantly pressing for this cure by environmental provision (unconsciously, or by unconscious motivation) but are unable to make use of it.

p. 157 It would appear that the time of the original deprivation is during the period when in the infant or small child the ego is in process of achieving fusion of the libidinal and aggressive (or motility) id roots. In the hopeful moment the child:

Perceives a new setting that has some elements of reliability.

Experiences a drive that could be called object-seeking.

Recognizes the fact that ruthlessness is about to become a feature and so

Stirs up the immediate environment in an effort to make it alert to danger, and organized to tolerate nuisance.

If the situation holds, the environment must be tested and retested in its capacity to stand the aggression, to prevent or repair the destruction, to tolerate the nuisance, to recognize the positive element in the antisocial tendency, to provide and preserve the object that is to be sought and found.

In a favourable case, when there is not too much madness or unconscious compulsion or paranoid organization, etc., the favourable conditions may in the course of time enable the child to find and love a person, instead of continuing the search through laying claims on substitute objects that had lost their symbolic value.

In the next stage the child needs to be able to experience despair in a relationship, instead of hope alone. Beyond this is the real possibility of a life for the child. When the wardens and staff of a hostel carry a child through all the processes *they have done a therapy that is surely comparable to analytic work*.

Commonly, parents do this complete job with one of their own children. But many parents who are well able to bring up normal children are not able to succeed with one of their children who happens to manifest an antisocial tendency.

In this statement I have deliberately omitted references to the relationship of the antisocial tendency to:

Acting out.

Masturbation.

Pathological super-ego, unconscious guilt.

Stages of libidinal development.

Repetition compulsion.

Regression to pre-concern.

Paranoid defence.

Sex-linkage in respect of symptomatology.

## Treatment

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p. 158 Briefly, the treatment of the antisocial tendency is not psychoanalysis. It is the provision of child care which can be rediscovered by the child, and into which the child can experiment again with the id impulses, and which can be tested. It is the stability of the new environmental provision which gives the therapeutics. Id impulses must be experienced, if they are to make sense, in a framework of ego relatedness, and when the patient is a deprived child ego relatedness must derive support from the therapist's side of the relationship. According to the theory put forward in this paper it is the environment that must give new opportunity for ego relatedness since the child has perceived that it was an environmental failure in ego support that originally led to the antisocial tendency.

If the child is in analysis, the analyst must either allow the weight of the transference to develop outside the analysis, or else must expect the antisocial tendency to develop full strength in the analytic situation, and must be prepared to bear the brunt.

## Note

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1. This idea seems to be implied in Bowlby's *Maternal Care and Mental Health* (1951), page 47, where he compares his observations with those of others and suggests that the different results are explained according to the age of a child at the time of deprivation.