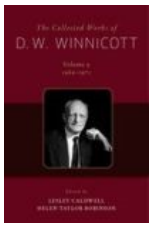

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CHAPTER

28 The Mother-Infant Experience of Mutuality

Donald W. Winnicott

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Abstract

In this paper, Winnicott points out that whereas it is generally known that there is almost infinite subtlety in a mother's management of her baby, it took a long time for psycho-analytic theory to reach to this area of living experience. He makes the comparison between the mother-infant experience and a work of art: resistance to examination of the former is, he argues, analogous to that which occurs when a work of art is being subjected to an analytic process.

Keywords: Winnicott, psychoanalysis, mother, infant, mutuality, dependence, subjective object, communication

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Written in 1969.

Whereas it is generally known that there is almost infinite subtlety in a mother's management of her baby, it took a long time for psycho-analytic theory to reach to this area of living experience. It is not difficult to see some of the reasons for the delay. Psycho-analysis, in its beginnings, had to emphasise the powerfulness of feelings and of conflicting feelings and had to explore the defences against them. In terms of childhood, psycho-analysis occupied itself for several decades with the Oedipus complex and all the complications that arise out of the feelings of boys and girls who have become whole persons related to whole persons.

Psycho-analysis gradually began to encroach on the experiences of younger children and explored the conflicts within the psyche and developed the concepts covered by words and moods and the persecutions from within and without. The psycho-analyst was always fighting the battle for the individual against those who ascribed troubles to environmental influence.

Gradually the inevitable happened and psycho-analysts, carrying with them their unique belief in the significance of details, had to start to look at dependence, that is to say, the early stages of the development

of the human child when dependence is so great that the behaviour of those representing the environment could no longer be ignored.

We are now right in the study of these very early mutual influences. We must expect resistance to the work we do, this time not because of the operation of repression and of anxiety in those who meet our work, but
p. 132 resistance that belongs to the feeling that a sacred area is being encroached upon. It is ↳ as if a work of art were being subjected to an analytic process. Can one be sure that the capacity to appreciate the work of art fully will not be destroyed by the search-light that is played upon the picture? It could indeed be well argued that these very early phenomena ought to be left alone, and I who have found myself making a study of them could not but insist that what we think we know about these intimacies is not useful reading material for artists or for young mothers. The sort of thing that can be discussed when we look at these early phenomena cannot be taught. It is remarkable, however, that certain people, even fathers and mothers, do like to read about these things after they have been through the experiences.

For our part as psychiatrists we have another reason why we must go ahead in our work with the examination of the subtleties of the parent-infant relationship. We have to take into consideration that this is an area of research which can throw light on the aetiology of the group of disorders that are labelled psychotic or schizoid, that is to say that are not the affective disorders or those that are called psycho-neurotic. In fact, if in our psycho-analytic work or in any other kind of psychotherapy we find ourselves temporarily involved with schizoid processes in our patients, we know that we shall be dealing in our consulting rooms with the same phenomena that characterise the experiences of mothers and infants. We shall be caught up in the immense needs of the dependent infant and in the counter-transference with the massive responsive processes which show us to some extent what is happening to parents when they have a child. As psychiatrists, therefore, we are left with no alternative but to go ahead and try to describe something of what we find, taking care not to put our views forward in the form of advice to mothers and fathers and child-minders, but to keep what we say in reserve for the use of colleagues who must find themselves involved from time to time with patients who develop dependence that is near absolute.

It is a relief that psycho-analysis has nearly come through the phase, which lasted a half-century, in which, when analysts referred to babies, they could only speak in terms of the baby's erotic and aggressive drives. It was all a matter of pregenital instinct, of oral and anal eroticism and reactions to frustration, with some rather wild additions in terms of natural aggressive behavior and destructive ideas, *agressivité.* Work of this kind had its value and continues to have value; but it is necessary now for analysts who refer to the nature of the baby to see what else is there to be seen. There are some shocks in store for the orthodox analyst if he looks further.

The Subjective Object

In order to study the way in which the human infant achieves the capacity to objectify, it is necessary to
p. 133 accept that at first there is no such capacity. To ↳ allow for this the theorist needs to be able to give up some tenets of which he has rightly been proud in all the years since Freud gave us the concept of the Oedipus complex, the idea of infantile sexuality, and the psycho-analytic technique for investigation that is the same as the psycho-analytic technique for therapy.

In this new area, the idea of the individual rather than of the environment (a major psycho-analytic contribution) needs to be modified or even dropped. When it is said that a baby is dependent, and at the beginning absolutely dependent, and this is really meant, then it follows that what the environment is like has significance because it is a part of the baby.

A baby is not what one may postulate by assessing that baby's potential. A baby is a complex phenomenon that includes the baby's potential *plus* the environment. To understand this idea we may look at a child of two. We may say: This child has not been the same since the new baby was born. In many cases we may diagnose illness patterns, and these illness patterns (shown as rigidity of defence organisations) call for treatment. The existence of illness patterns must not be allowed to obscure the reality that the child in question is a child *with a younger brother or sister.* With the same potential, this child would be different if he or she were the youngest child or the only child, or if a baby had been born but had died. No one would object to this idea in terms of a two-year-old, which of course does not alter the fact that it is possible to give effective psychotherapy in respect of the child's psychopathology. Psychopathology, however, is a different

thing from health and from the effect on the child of the innumerable environmental features that belong to the child who is not far from absolute dependence and is but a short way along the path toward independence.

To carry the argument back to the very early stages, the significance of the environment for the baby when there is near-absolute dependence is such that *we cannot describe the baby without describing the environment.*

The stage of absolute dependence or near-absolute dependence belongs to the state of the baby at the beginning who has not yet separated a NOT-ME from what is ME, of the baby who is not yet equipped to perform this task. In other words, the object is a subjective object, not objectively perceived. Even if it is repudiated, put over there, the object is still an aspect of the baby.

How does the next stage come about? Its development and establishment are not due to the operation of the child's inherited tendencies (toward integration, object-seeking, psycho-somatic collusion, etc.). In any one case it may never happen in spite of perfectly good inherited tendencies in the baby. This development takes place *because of the baby's experiences of the mother's* (or mother substitute's) *adaptive behaviour.* The mother's adaptive behaviour makes it possible for the baby to find outside the self that which is needed and expected. By means of the *experience* of good-enough mothering the baby goes over into objective perception, having inherited the tendency to do this *and* having been given the perceptual equipment and opportunity.

p. 134 In order to understand the part played by the mother it is necessary to have a concept such as the one that I have described in 'Primary Maternal Preoccupation' [CW 5:2:16]. I have tried to show that we may expect good-enough mothering from the mothers of the world, and of the past ages, because of something that happens to women during pregnancy, something that lasts for some weeks after the baby's birth unless a psychiatric disturbance in the mother prevents this temporary change in her nature from occurring.

In addition, it is necessary to be able to think of a baby as beginning to have some capacity for objectivity, and yet being generally unable to objectify, with a forward and backward movement in this area of development.

Communication

In order to clarify our concepts we can usefully bring ourselves to think in terms of communication. To explain how this can help I wish to give an example.

From birth a baby can be seen to take food. Let us say that the baby finds the breast and sucks and ingests a quantity sufficient for satisfaction of instinct and for growth. This can be the same whether the baby has a brain that will one day develop as a good one or whether the baby's brain is in fact defective or damaged. What we need to know about is the communication that goes or does not go with the feeding process. It is difficult to be sure of such matters by the instrument of infant-observation, though it does seem that some babies watch the mother's face in a meaningful way even in the first weeks. At 12 weeks, however, babies can give us information from which we can do more than guess that communication is a fact.

> ***Illustration 1.*** Although normal babies vary considerably in their rate of development (especially as measured by observable phenomena), it can be said that at 12 weeks they are capable of play such as this: settled in for a (breast) feed, the baby looks at the mother's face and his or her hand reaches up so that in play the baby is feeding the mother by means of a finger in her mouth.

It may be that the mother has played a part in the establishment of this play detail, but even though this is true it does not invalidate the conclusion that I draw from the fact that this kind of playing can happen.[i]

I draw the conclusion from this that, whereas all babies take in food, there does not exist a communication between the baby and the mother except in so far as there develops a mutual feeding situation. The baby feeds and the baby's experience includes the idea that the mother knows what it is like to be fed.

p. 135 If this happens for all to see at 12 weeks, then in some way or other it can (but need not) be true in some obscure way at an earlier date.

In this way we actually witness a *mutuality* which is the beginning of a communication between two people; this (in the baby) is a developmental achievement, one that is dependent on the baby's inherited processes leading toward emotional growth and likewise dependent on the mother and her attitude and her capacity to make real what the baby is ready to reach out for, to discover, to create.[1]

Babies feed, and this may mean much to the mother, and the ingestion of food may give the baby gratification in terms of drive satisfactions. Another thing, however, is the communication between the baby and the mother, something that is a matter of experience and that depends on the mutuality that results from cross-identifications.

Melanie Klein has done full justice to the subject of projective and introjective identifications, and it is on the basis of her development of Freud's ideas of this kind that we are able to build this part of theory in which communication has significance greater than that which is usually called 'object-relating'.[2]

In giving this illustration, I have remained close to the familiar framework of psycho-analytic statements concerning object-relating because I wish to keep open the bridges that lead from older theory to newer theory. Nevertheless, I am obviously near to Fairbairn's statement made in 1944 that psycho-analytic theory was emphasising drive-satisfaction at the expense of what Fairbairn called 'object-seeking'. And Fairbairn was working, as I am here, on the ways in which psycho-analytic theory needed to be developed or modified if the analyst could hope to become able to cope with schizoid phenomena in the treatment of patients.[3]

At this point it is necessary to interpolate a reference to the obvious fact that the mother and the baby come to the point of mutuality in different ways. The mother has been a cared-for baby; also she has played at babies and at mothers; she has perhaps experienced the arrival of siblings, cared for younger babies in her own family or in other families; and she has perhaps learned or read about baby care and she may have strong views of her own on what is right and wrong in baby management.

The baby, on the other hand, is being a baby for the first time, has never been a mother, and has certainly received no instruction. The only passport the baby brings to the customs barrier is the sum of the inherited features and inborn tendencies toward growth and development.

Consequently, whereas the mother can identify with the baby, even with a baby unborn or in process of being born, and in a highly sophisticated way, the baby brings to the situation only a developing capacity to achieve cross-identifications in the *experience of mutuality* that is made a fact. This mutuality belongs to the mother's capacity to adapt to the baby's needs.[4]

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Mutuality Unrelated to Drives

It is possible now to enter the deep waters of mutuality that does not directly relate to drives or to instinct tension. Travelling towards this, another example may be given.

Like so much of what we know of these very early babyhood experiences, this example derives from the work that has to be done in the analysis of older children or of adults when the patient is in a phase, long or short, in which regression to dependence is the main characteristic of the transference. Work of this kind always has two aspects, the first being the positive discovery in the transference of early types of experience that were missed out or distorted in the patient's own historical past, in the very early relationship to the mother; and the second being the patient's use of the therapist's failures in technique. These failures produce anger, and this has value because the anger brings the past into the present. At the time of the initial failure (or relative failure) the baby's ego-organisation was not organised sufficiently for so complex a matter as anger about a specific matter.

Analysts with a rigid analytic morality that does not allow touch miss a great deal of that which is now being described. One thing they never know, for instance, is that the analyst makes a little twitch whenever he or she goes to sleep for a moment or even wanders over in the mind (as may well happen) to some fantasy of his or her own. This twitch is the equivalent of a failure to hold in terms of mother and baby. The mind has dropped the patient. (These cases put a strain on us. There are long periods of quiescence, sometimes at a room temperature that is higher than the analyst would choose to work in.)

> ***Illustration 2.***[5] A boy of 6 years was able to give me accurate information in a one-session therapeutic consultation about the way his mother went to sleep while holding him when he was 14 months old.
>
> This was the nearest he could get to giving me the information that his mother had a depressive illness at that date which started with her developing a tendency to go to sleep.
>
> In the language of this paper, the boy experienced a series of failures of communication at the points at which the mother became withdrawn.
>
> My understanding of the child's communication in this one session enabled the boy to go forward in his development. A year later when I saw him, he was a normal boyish boy who brought his younger brother to see me. This was his own idea. He remembered the work that we had done together.

> ***Illustration 3.*** This example is taken from the analysis of a woman of 40 years (married, two children) who had failed to make full recovery in a six-year analysis with a woman colleague. I
p. 137 agreed with my colleague ↳ to see what analysis with a man might produce, and so started a second treatment.
>
> The detail I have chosen for description has to do with the absolute need this patient had, from time to time, to be in contact with me. (She had feared to make this step with a woman analyst because of the homosexual implications.)
>
> A variety of intimacies were tried out, chiefly those that belong to infant feeding and management. There were violent episodes. Eventually it came about that she and I were together with her head in my hands.
>
> Without deliberate action on the part of either of us there developed a rocking rhythm. The rhythm was rather a rapid one, about 70 per minute (c.f. heartbeat), and I had to do some work to adapt to this rate. Nevertheless, there we were with *mutuality* expressed in terms of a slight but persistent rocking movement. We were *communicating* with each other without words. This was taking place at a level of development that did not require the patient to have maturity in advance of that which she found herself possessing in the regression to dependence of the phase of her analysis.
>
> This experience, often repeated, was crucial to the therapy, and the violence that had led up to it was only now seen to be a preparation and a complex test of the analyst's capacity to meet the various communicating techniques of early infancy.

This shared rocking experience illustrates what I wish to refer to in the early stages of baby care. The baby's instinctual drives are not specifically involved. The main thing is a communication between the baby and the mother in terms of the anatomy and physiology of live bodies. The subject can easily be elaborated, and the significant phenomena will be the crude evidences of life, such as the heartbeat, breathing movements, breath warmth, movements that indicate a need for change of position, etc.

Basic Care

These primitive techniques that have intercommunication as a byproduct lead naturally to still more primitive or fundamental interactions that are of the nature of silent communications; that is to say, the communication only becomes noisy when it fails.

Here I am in the area covered, I think, by Hartmann's phrase, 'the average expectable environment', though I cannot be sure that Hartmann intended to refer to these very early silent communications.

What I have to say here is covered by the term 'holding'. A wide extension of 'holding' allows this one term to describe all that a mother does in the physical care of her baby, even including putting the baby down
p. 138 when ↳ a moment has come for the impersonal experience of being held by suitable non-human materials.

In giving consideration to these matters, it is necessary to postulate a state of the mother who is (temporarily) identified with her baby so that she knows without thinking about it more or less what the

baby needs. She does this, in health, without losing her own identity.[6]

I have tried elsewhere to develop the theme of the developmental processes in the baby that need, for their becoming actual, the mother's holding. The 'silent' communication is one of reliability which, in fact, protects the baby from *automatic reactions* to impingement from external reality, these reactions breaking the baby's line of life and constituting traumata. A trauma is that against which an individual has no organised defence so that a confusional state supervenes, followed perhaps by a reorganisation of defences, defences of a more primitive kind than those which were good enough before the occurrence of the trauma.[7]

Examination of the baby being held shows that communication is either silent (reliability taken for granted) or else traumatic (producing the experience of unthinkable or archaic anxiety).

This divides the world of babies into two categories:

1. Babies who have not been significantly 'let down' in infancy, and whose belief in reliability leads towards the acquisition of a personal reliability which is an important ingredient of the state which may be termed 'towards independence'. These babies have a line of life and retain a capacity to move forward and backward (developmentally) and become able to take all the risks because of being well insured.

2. Babies who have been significantly 'let down' once or in a pattern of environmental failures (related to the psychopathologic state of the mother or mother-substitute). These babies carry with them the experience of unthinkable or archaic anxiety. They know what it is to be in a state of acute confusion or the agony of disintegration. They know what it is like to be dropped, to fall forever, or to become split into psycho-somatic disunion.

In other words, they have experienced trauma, and their personalities have to be built round the reorganisation of defences following traumata, defences that must needs retain primitive features such as personality splitting.[8]

Of course, the world of human beings is not made up of examples of these two extremes. Those who are started off well, as most babies surely are, may be let down at later stages and suffer traumata of a kind; and *per contra* babies who have been badly let down in early stages may be almost 'cured' of their disastrous beginnings by therapeutic care at later stages.

p. 139 Nevertheless, it is valuable for the student of human nature to keep in mind the two extremes. Especially is it valuable for the psychiatrist and the psychotherapist to know of these matters, since a study of the aetiology and psychopathology of the schizoid states and of the special features of the schizoid or psychotic transference leads right back to the reorganisation of defences of primitive quality following the experienced acute confusional states of early infancy; these follow traumas in the area in which the baby (for healthy development) must be able to take reliability for granted, the area that is almost covered by an extended use of the term 'holding'. But reliable holding of a baby is something that needs to be communicated, and this is a matter of the baby's experiences. Just here psychology involves communication in physical terms, the language of which is mutuality in experience.

Notes

1. This has a direct relationship to Sechehaye's term 'symbolic realization', which means enabling a real thing to become a meaningful symbol of mutuality in a specialised setting. See M. A. Sechehaye, *Symbolic Realization* (New York: International Universities Press, 1951).

2. Melanie Klein, *The Psycho-Analysis of Children* (London: Hogarth Press, 1932).

3. See W. R. D. Fairbairn, *Psycho-Analytic Studies of the Personality* (London: Tavistock, 1952), page 88: 'since it is only ego structures that can *seek* relationships with objects' (my italics).

4. The word 'need' has significance here just as 'drive' has significance in the area of satisfaction of instinct. The word 'wish' is out of place as it belongs to sophistication that is not to be assumed at this stage of immaturity that is under consideration.

5. Described at length as Case 4, 'Bob' [CW 10:1:4], in *Therapeutic Consultations in Child Psychiatry* (London: Hogarth Press; New York: Basic Books, 1971); also in the *International Journal of Psycho-Analysis* 46 (1965) under the title 'A Clinical Study

of the Effect of a Failure of the Average Expectable Environment on a Child's Mental Functioning'.

6. In psychopathology she may be so much identified with the baby that she loses her maternal capacity and, if she retains some sanity, she hands the baby over to the care of a nurse. In this way she vicariously gets well held, and one can see in this a natural seeking for that which the patient may get in the analytic transference in phases of regression to dependence.

7. Masud Khan has developed this aspect of trauma; see M. M. R. Khan, 'Ego Distortion, Cumulative Trauma, and the Role of Reconstruction in the Analytic Situation', *International Journal of Psycho-Analysis* 45 (1964); also in *The Privacy of the Self* (London: Hogarth Press, 1974).

8. Phobic states are loose organisations in defence against defence failures.

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Notes

Editorial See 'Getting to Know Your Baby', 1944 [CW 2:5:8].
Note i