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Donald Winnicott: The Emerging Self

Winnicott is an elusive figure in Object Relations, at once extrovert and enigmatic. He pursued his own idiosyncratic course amidst the political and theoretical storms of the war years. He was perhaps unique in staying close to Melanie Klein for many years, even analysing her son, whilst maintaining his autonomy. Winnicott was a leading member of the middle or independent group, analysts who refused to take either side in the Freud–Klein controversies and who valued flexibility and open-mindedness over dogmatism. His enquiring, experimental approach brought together his two specialisms, paediatrics and psychoanalysis, in highly original ways. He produced talks and papers, brief and lengthy, on a multitude of subjects. Gripping and evocative, his musings roam the world of applied psychoanalysis as well as his rich clinical experience.

It is a paradox that the accessibility which is such an attractive feature of his writing is limited to his professional style. His personal life has tended to be presented in an idealised fashion by himself, his widow Clare Winnicott and other advocates of his work (Davis and Wallbridge 1981; C. Winnicott 1983; D. Winnicott 1989). It is therefore difficult to make an appraisal of his personal life and its relationship with his work.

Life

Donald Winnicott was born in 1896, the youngest child and only boy in a middle-class business family in Plymouth, England. Clare Winnicott (1983) describes his parents as religious but not rigid, and his upbringing as free, open and loving. Winnicott seems to have been the focus of attention of his mother, sisters, aunt, nanny and governess, who with his more distant father formed a large and relaxed household; there were also older cousins who lived close by.

The Winnicott family comes over as a warm and rather female-dominated community in which Winnicott developed as a valued

and cherished individual. There is little suggestion of conflict or unhappiness, except briefly when as a nine-year-old he decided he was 'too nice'. Going to boarding school at thirteen was an adventure: his father had decided to send him, according to Winnicott, when he was disturbed at hearing his son say 'drat'. Although this can hardly have been the deciding reason, Winnicott seems to have found this act of paternal authority reassuring, agreeing in later life that he had indeed been associating with the wrong kind of boy. His letters communicate his enjoyment of the larger school community as well as the closeness he maintained with his family.

Winnicott first thought of becoming a doctor when he had broken his collar bone, because he did not want to be dependent on doctors throughout his life. He was fearful about the disappointment this would cause his father who naturally expected his only son to enter the family business, and needed the support and intervention of a friend before he felt able to commit himself to this decision. He studied medicine at Cambridge University and served briefly in a medical capacity during the First World War while he was still a student. The friends and contemporaries who were killed remained a sadness which haunted him throughout his life (Winnicott 1989: 11).

Winnicott's first marriage is seldom mentioned. He married Alice Taylor in 1922 when he was twenty-seven, having had some difficulty, according to Clare Winnicott, in becoming independent of his family. Alice has been variously described as a potter, as an opera singer and as psychologically disturbed (Goldman 1993: 68–9). The marriage was difficult from the outset, and Winnicott is said to have stayed with her until he felt she could manage without him. He may also have been waiting until after his father's death, in what would be a close parallel to his anxiety about disappointing his father's hopes that he would enter the family business. Winnicott and Alice did not have children and they eventually separated in 1949; he maintained contact with her even after he remarried two years later. The psychoanalyst Margaret Little, who was then his patient, reports (Little 1990) that when his marriage ended, Winnicott sank into a depressed state and suffered the first of the coronaries which afflicted him over the last twenty years of his life.

His second wife, Clare Britton, was a psychiatric social worker with whom he had worked during the Second World War. They had been involved in the setting up and running of hostels for children who had been evacuated but who were too disturbed to be cared for in foster homes. Clare also became a psychoanalyst and remained a

staunch supporter and advocate of his work throughout his life and after his death.

Like Fairbairn's first wife, Alice Winnicott is commonly seen as the cause of the difficulties in their marriage, with her husband being portrayed as sacrificing his youth to her care. However, this must be a partial view, as his distress when they separated makes clear. In a paper entitled 'Hate in the Countertransference', Winnicott describes a disturbed and difficult nine-year-old boy who lived with them for three months during the war and whom Winnicott hoped to treat: 'My wife very generously took him in and kept him for three months, three months of hell', he wrote. 'He was the most lovable and most maddening of children, often stark staring mad ... It was really a whole-time job for the two of us together, and when I was out the worst episodes took place' (Winnicott 1975: 199–200).

This suggests that Alice was not completely incompetent and dependent; and in emphasising both her generosity and her willingness to look after this child, Winnicott indicates that he felt he had asked a lot of her.

This boy was not the only patient to be taken into their home. A colleague, Marion Milner, published an account of her work with a regressed and needy schizoid patient, 'Susan' (Milner 1969). Winnicott had in fact asked her to work with Susan and paid for her treatment, and she lived with the Winnicotts for six years. Milner indicates (1969: 3) that it was Alice who pressed for Susan to leave hospital and come to live with them. The greatest burden would again have fallen on her as Winnicott would have been working or writing all day. The length of time Susan stayed was remarkable, only ending when the Winnicotts' marriage broke up. Dodi Goldman (1993) speculates on how the presence of another woman could have contributed to their separation after twenty-seven years of marriage.

Winnicott clearly saw himself as a carer, and in other cases too he seems to have become highly involved and perhaps entangled with some of his regressed patients (see Little 1990). Alice also, in her willingness to bring needy people into the household, took up a caring role. In part this demonstrates an unusual kindness and generosity in them both and a way of expressing their concern for others in the absence of children of their own. Perhaps they also had the need for a vulnerable other into whom they could project their own feelings of dependency, creating a buffer between them in the process. Their childlessness is often put down to Alice's problems, but Goldman wonders additionally whether Winnicott would have found real fatherhood demanding and constricting: it might have cramped his style. As it was, he took a role which was in some ways analogous to his experience of his own father as an idealised distant figure.

Winnicott turned to psychoanalysis partly through the influence of Thomas Horder, an innovative physician who encouraged him above all to listen to his patients. He also seems to have encountered some personal difficulties, alluded to vaguely as feeling inhibited and being unable to remember his dreams (Hughes 1989: 19; Jacobs 1995: 10). Probably more significantly, it was shortly after he married Alice that he entered analysis. On the advice of Ernest Jones, he saw James Strachey, the translator of Freud's work who had himself been analysed by Freud; Strachey then recommended Klein as a supervisor for his work with children, which as a paediatrician he was in a good position to develop. He must have started working with Klein soon after her arrival in Britain (Winnicott 1962a). He had a second analysis with Joan Rivière, a leading Kleinian.

Winnicott thus had early and full experience of both Freudian and Kleinian psychoanalysis. Both analyses seem to have been problematic for him at times and his ten years with Strachey and five years with Rivière left him unsatisfied. Strachey, he wrote rather ambivalently to Jones, 'adhered to a classical technique in a cold-blooded way for which I have always been grateful' (quoted in Goldman 1993: 74). He felt that Strachey underestimated the importance of relationship in development and overestimated the power of interpretation in the analytic process. Strachey, for his part, had his own difficulties with Winnicott, finding him misguided in his deviation from Freudian orthodoxy and late in paying his bills.

Winnicott found his analysis with Joan Rivière both enlightening and disappointing. He was inspired by Klein's ideas, but was unsuccessful in his attempts to induce either Klein or Rivière to offer some endorsement of his own very different work. The psychoanalyst John Padel has suggested that many of Winnicott's papers were written with the aim of getting Klein to modify her theories (Grosskurth 1986: 399). If this was the case, it was clearly a non-starter as a plan. The ideas he was building – based on the importance of the environment as against instinctual conflict – were in blunt opposition to Klein's. For her to have accepted his views would have weakened both the thrust of her theoretical views and her political position in the British Psycho-Analytical Society. Winnicott may have become involved in an opposition which was not going to be resolved, but in defining his own ideas against those of Klein he probably attained a greater clarity than he would otherwise have done.

Winnicott maintained the two strands of his working life, paediatric medicine and psychoanalysis, throughout his career, to the enrichment of both disciplines. He held a clinic at Paddington Green Children's Hospital in London for over forty years and also worked at The Queen Elizabeth Hospital for Children in the East End of London. His wife and colleagues estimated that he had seen over sixty thousand cases in his working life, giving him a far broader experience of ordinary people than other psychoanalysts gained. He improvised ways of using psychoanalytic concepts and attitudes to help families and children for whom psychoanalytic treatment was not an option. Many of his papers describe brief interactions with a baby or child, or intermittent and intuitive family support to help disentangle a block in a child's development (Winnicott 1955, 1960a). He also experimented with irregular, 'on demand' treatment of children, again as an alternative to normal ongoing treatment. One such treatment was written up as *The Piggle* (Winnicott 1977).

Winnicott worked extensively during the Second World War in the management of child evacuees. He was involved in setting up and consulting to hostels for children whose placements in foster families had broken down as a result of their disturbed behaviour. The primary importance he attributed to the environment in children's development is demonstrated in his focus on the management as well as the treatment of delinquent children (Winnicott 1984).

Winnicott also distinguished between management and treatment in his psychoanalytic work with borderline patients, whom he considered were often unable to benefit from the therapeutic distance suitable for the less disturbed. His view of regression as a therapeutic opportunity rather than a defence led him to experiment with different ways of facilitating psychic growth in highly dependent patients who had regressed to early stages of development. His responses to such patients included open-ended sessions of sometimes several hours in length, physical holding, sessions on demand and support outside sessions. These experiments have been welcomed as bringing a new humanity to psychoanalysis, but Winnicott has also been criticised for holding an arrogant attitude of omnipotence and failing to learn from previous similar experiments which had mostly turned out badly.

Again, the truth is likely to be complex rather than simple. Many of Winnicott's patients must have benefited from his genuine care and concern, and his efforts to meet even the extreme needs of his patients in an imaginative and flexible way are impressive. Other

patients, however, must have suffered from his keenness to provide all the care himself. This led him to propose irregular treatment with him rather than referring patients to colleagues who could have offered them more consistency.

Winnicott is commonly described as playful, spontaneous, sparkling and deeply empathic; perhaps a bit of a *puer*, a Peter Pan, even a 'crypto-prima donna' (Grosskurth 1986: 399). Some people saw him as a loner, for all his apparent sociability. His work is strangely silent, in content and tone, on the devastating effects of the two world wars through which he lived. Perhaps his pessimism was to some extent split off from his optimism; this would make his hopeful side particularly attractive, while his more cynical side would recede from view.

There is more to Winnicott than the spontaneous and generous man who emerges most clearly in his writing. He was canny in the way he limited the situations and patients he worked with, consciously preserving his sensitivity. The ease with which he let go of patients with whom the reader has become quite involved can jar. This is not surprising in view of the huge numbers of patients he saw, yet it indicates a shrewd self-interest which is not immediately apparent from the empathic warmth of his writing.

It sometimes seems as though there is a thread of self-consciousness running alongside his wonderful imagination. The double negatives, the poetic language, even the paradoxical prayer in his autobiographical writing: 'Oh God! Let me be alive when I die' (Winnicott 1989: 4), can seem contrived. Perhaps his warmth and imagination were in part techniques to cover his isolation: ways of bringing people not exactly under his control, but into his realm. His sometimes patronising tone when talking to mothers in particular – even the term 'the ordinary devoted mother' – gives the same impression of subterranean arrogance. This more complex side of Winnicott is also betrayed by the personal difficulties he fleetingly alludes to, which suggest buried pre-symbolic wounds. He mentions a disturbing symptom of following every sound he heard with his larynx as though subvocalising (Winnicott 1963a), and a persistent sense of something rotten in the centre of his head (Winnicott 1968). A poem reveals the thought that perhaps his life, even his very joyfulness, was a way of restoring a depleted, depressed mother: 'to enliven her was my living' (quoted in Goldman 1993: 45).

A picture emerges of a creative and idiosyncratic man, devoted to his work, who developed a unique capacity to slip into immediate communication with anyone from a baby to a delinquent to a

borderline adult. The narcissistic strand in Winnicott's make-up was probably connected with the difficulties that enabled him to tune into primitive states of being. It may have linked up with his unexpected view of the core of the self as private, out of reach, 'incommunicado' (Winnicott 1963b). This hidden, perhaps troubled side of Winnicott contrasts with the playful old man described by Clare – riding down London's Haverstock Hill with his feet on the handle-bars of his bicycle, or climbing to the top of a tree (C. Winnicott 1983).

Winnicott died peacefully in 1971. He left followers and dissenters who held him in affection and respect, and some who saw him as misguided and a lazy thinker. The Squiggle Foundation in London, devoted to the dissemination of his ideas, was named after the doodling game he played with children (Winnicott 1964–68). The name captures the simplicity and imagination of his kind of psychoanalysis. It also offers the temptation to accept at face value the childlike Winnicott so often presented to us, leaving aside the complexities which make him a person rather than a myth.

Theory

Overview

Guntrip described Winnicott as first and foremost a clinician, a people-person, and, unlike Fairbairn, 'more revolutionary in practice than in theory' (Guntrip 1975). Winnicott's contribution to Object Relations lies more in the field of practical application than in theory. He emphasised above all the necessity of making concepts one's own before they can be used creatively.

Winnicott's writing style is impressionistic rather than analytical. He aims to re-create in the reader the state of mind he is writing of, rather than to present a clear argument. This makes him emotionally attractive to read, but maddeningly elusive to grasp.

Winnicott focuses on paradox, transition and ambiguity. He charts the emergence and vicissitudes of the self in early development, in disturbance, in delinquency and in psychosis. His arena is the borderline between inner and outer, self and other, the subjective and the objective. 'There is no such thing as a baby', he asserts strikingly and provocatively (Winnicott 1952a), because where there is a baby there is always a caring adult. He is pointing out the absolute sociability of human beings; the individual emerges, always

incompletely, from a matrix of communality which is also held within the self. He thus places himself firmly within the Object Relations school, but does not throw out drive theory and instinctual gratification. Instead, he sees physical life as a challenge to our capacity to contain and make meaning of our excitement. While it can easily overwhelm the sense of self, physicality is also the core of realness which he characterised rather than defined as the 'true self'.

Winnicott disagreed, diplomatically, with Freud and Klein on the primacy of instinctual conflict; he suggested (Winnicott 1959–64) that the concept of the death instinct was superfluous rather than wrong. He sought to balance Klein's emphasis on unconscious phantasy arising from internal conflict with a far greater inclusion of the environment and its effects. In his optimistic fashion, he made a plea for Klein's depressive position to be renamed 'the stage of concern'. Unusually for a psychoanalyst, he saw human beings as on the whole healthy. The human race is a going concern because of the good-enough care given to children through the generations. Many of his case histories include such comments as: 'he comes within the wide definition of the term normal' (Winnicott 1971: 8).

Winnicott's infant becomes a personal self through the protective care of the 'good-enough mother'. Through her initial close identification with her baby, which he termed 'primary maternal preoccupation', she fosters an illusion of oneness with her baby which makes him feel secure and even omnipotent. As this intense and intuitive early relationship develops it broadens out into a less focused, more everyday mode of being together. Gradually the baby moves through bearable experiences of frustration and disillusionment to the realisation that his own powers, while real, are limited. The mother enables this to happen through her natural recovery from her near-obsession with her new-born baby. As she begins to take up her own separate life again, the baby learns to develop his own resources. Winnicott suggests that with an 'average expectable environment' of loving care, the baby gathers a sense of continuity and coherence which coalesces into personal identity, with an emotional core of togetherness which he terms 'ego-relatedness'. This sense of inner relatedness is the foundation on which autonomy and independence rest.

This profoundly social view of early development is difficult to reconcile with Winnicott's view of the centre of the self as unsocial (Winnicott 1963b). There is no account of where this totally private self comes from or what sustains it. Perhaps, like Freud's death instinct, the idea derives from emotional conviction rather than

intellectual thought. His descriptions conjure up the still centre of a dynamic sphere, a point rather than a zone.

Winnicott takes this developmental process of moving from illusion to disillusion as a recurrent focus of attention. Although he did not develop a coherent theoretical structure, he evolved ideas and perspectives which have stood the test of time, entering into mainstream psychotherapeutic thinking and sometimes into social awareness too.

Privation and Psychosis

Winnicott described psychosis as an 'environmental deficiency disease' (Winnicott 1949a, 1952b). He did not discount genetic factors, but he saw the primary cause as deficiencies in care during the earliest stages of self-formation, 'absolute dependency' (Winnicott 1963c). At this stage, the baby is not yet aware of the differentiation of self and environment and therefore does not perceive an environment, or an other, as such. The wound that the baby suffers is thus not an external lack to which he could react but a trauma, a brokenness, which runs throughout his subjectivity. He termed this deficiency 'privation': the absence of factors which were needed for the child to develop and mature in a straightforward way. Winnicott thus defines psychosis as arising from a disastrous early failure of relationship, albeit a failure that may be particularly hard to avoid with some children who may be especially vulnerable.

What is the nature of the relationship between the infant and mother before the infant is aware of anyone separate to relate to? Winnicott suggests that while the infant has drives, he should not be seen as a bundle of bodily needs seeking gratification, but rather as a person who is perpetually 'on the brink of unthinkable anxiety' (Winnicott 1962b). The 'good-enough mother' holds the baby together through her attunement to his needs and inner states; the baby perceives her not as a distinct object, but as a surrounding presence. Winnicott refers to the mother thus experienced by the young infant as the 'environment mother' (Winnicott 1963d).

The baby is at first aware only of his relative well-being or, conversely, the threat or actuality of falling into an unbearable state which Winnicott calls 'annihilation'. Winnicott describes this experience in graphic terms, as the 'primitive agonies' of going to pieces, falling forever, having no relation to the body, having no orientation in the world and complete isolation with no means of

communication. These are horrors which surface in later life as psychotic or borderline-state anxieties in which one's very being seems threatened.

Winnicott identified three ways in which the mother protects the baby from these experiences: 'holding', 'handling' and 'object-presenting'. Problems in these areas correlate with specific anxieties and the stunting of differing emotional capacities.

Holding is both physical and emotional. The good-enough mother contains and manages the baby's feelings and impulses by empathising with him and protecting him from too many jarring experiences. Her protective holding is expressed through the way she carries, moves, feeds, speaks to and responds to her baby, and in her understanding of his needs and experience. She forestalls the shock of sudden movement, physical pain or distress, loud noises and bright lights, until the baby is able to manage these without shutting down his being. This means that the baby is able to remain in a state of 'unintegration', a relaxed and undefended openness in which his different experiences can join together in an unbroken stream. The mother's holding enables the baby's 'true self', the spontaneous experience of being, to develop coherence and continuity. During periods of unintegration the baby lays down his sense of existing over time and space as one being, existentially real and personally authentic.

When the mother cannot give the baby the kind of holding and protection he needs, he is jolted into shock and reaction. Rather than simply 'going on being', he has to try to hold himself together against the threat to his being, a threat which may be external, like a sudden noise, or internal, such as hunger or a need for contact. Not to react would result in the appalling experience of unintegration without being held, an experience of annihilation that is fought against at all costs. But while fighting against it, there can be no simple continuous state of being, and the baby cannot develop a sense of effortlessly existing as a real, alive, continuous, unified being. If these states of reactivity are frequent and prolonged, the baby, and then child, will feel to some extent unreal, inauthentic, afraid of 'going to pieces'. He may cover his 'true self' with a 'false self', hiding his fraught inner state behind an outward appearance of coping and compliance (Winnicott 1960b). If even this fails, the fragmentation of psychosis may be revealed, with the psychotic person experiencing himself in bits and speaking as different people, unable to maintain a sense of wholeness, coherence and continuity of self.

The second aspect of this early, pre-differentiated relationship arises from the mother's handling. At its best, her sensitive touch and responsive care of the baby's body will enable him to experience physical and emotional satisfaction in an integrated way. This will help the baby to bring together the worlds of sensation and emotion, building a stable unity of mind and body. The person who received enough sensitive handling in early life will experience his mental, emotional and physical capacities as connected and personal in 'true self' living.

By contrast, the baby may feel that his bodily functions are managed impersonally, or he may be left alone, emotionally or physically, for longer than he can bear. He may attempt to cope by identifying with his mind rather than his body, despising his physical needs and distancing himself from physical experience. He may feel that his 'true self' is ethereal rather than corporeal. He is trying to cope with the agony of 'having no relation to the body', an experience which may surface in later life as feeling unreal, depersonalised, floating in a void without being anchored to the bodily self. This feeling of disembodiment and unreality can include 'having no orientation': no sense of specific connection to the world which includes the body. At its worst, this can be a literal sense of not knowing which is up or down, inside or outside, forwards or backwards. All feels vague and disconnected, as though floating or spinning in an endless vacuum without a reference point or anything distinct.

Object-presenting is the third aspect of mothering Winnicott defines. It is the way in which the mother brings the outside world to the baby. When this goes well, the baby is ready to receive and explore and the mother is happy to allow him some independence. Winnicott often describes object-presenting in terms of feeding. The sensitive mother allows the baby to actively find and feed from the breast or bottle, rather than thrusting the nipple in his mouth before he knows it is there or keeping him waiting for longer than he can manage. Similarly, if the baby is allowed to reach for and find a toy, smile or burble to a mother who then responds, bring about change and satisfaction through his own efforts, he feels as though he is actually creating the world. He seems to be living in a world of 'subjective objects', at once part of him and yet novel, which are under his magical control. Through presenting objects and experiences in a way which is sensitive to her baby's state, the mother helps him build a primitive conviction of omnipotence and 'dual unity' which is an essential prelude to disillusion. The baby develops a sense of oneness and trust in the world, which grows into an appreciation

of both his connection with others and his separateness. He gains a confidence in his ability to reach out, connect and make changes in the world, and he expects to be met with understanding and responsiveness.

Various problems may arise in the arena of object-presenting. An anxious mother may forestall her baby's reaching out by feeding him before he is hungry, lifting him before he is awake, playing with him before he has a chance to want contact. Conversely, a depressed, harassed or self-absorbed mother may not respond sufficiently to her baby's demands or may not be attuned to him. In all such cases, the baby may find difficulty in developing a realistic self-confidence. The baby whose autonomy was smothered may expect the world to fall in with his needs without effort on his part. He may fear being engulfed and taken over by others and have an undeveloped sense of his personal boundaries. The child whose parents could not respond to him sufficiently may not expect the world to understand and empathise with him. He will feel safer relating to the world from a 'false self' position, adapting to the needs of the other rather than expressing his true needs. At its worst, failure in the area of object-presenting results in the conviction that people are not only separate, but isolated. This is the primitive agony of not being able to communicate because there seems to be no way of connecting with anyone, even oneself. More commonly, there is a sense of distrust, futility and loneliness. If there seems to be little point in trying to relate to others, the person may elevate self-sufficiency from a necessity to an ideal.

Privation of attuned holding, handling or object-presenting will not feel like an external failure to the baby who has not yet become aware of separateness. Rather, he will be overwhelmed by stimuli from internal or external sources which he cannot manage, at an intensity that breaks up his peaceful state of simply being. Winnicott termed these traumatic experiences 'impingements', fractures in the wholeness of being which the baby has no option but to accommodate. At an extreme, he will not be able to develop further on an unanxious basis, and will have to construct a defensive mode of survival over the top of unbearable anxiety. False-self living, emotional withdrawal and actively-induced disintegration are all protective devices for the traumatised true self, which may remain hidden, broken or unestablished, but is never extinguished. Winnicott's passionate belief in the true self led him to make horrified protests about the psychiatric treatment of leucotomy (Winnicott

1949b), which he saw as the barbaric destruction of what is most preciously human.

Winnicott was acutely sensitive to the hazards of this early stage of life and the kind of suffering that arose from it. This made him highly empathic to his psychotic and borderline child and adult patients, whom he thought of in terms of the baby at the stage of absolute dependence. He remarked that the patient who is afraid of breaking down does not fear an unknown situation, but a return to a previous, unbearable state of dereliction (Winnicott 1963e), an insight which can be a real help when people are afraid of falling apart. Winnicott emphasised that under the threat of psychotic anxieties (the primitive agonies), we do not need the analysis of our problems, but rather the kind of sensitive, involved and unsentimental care that the 'good-enough' mother gives naturally to her young baby (Winnicott 1967a).

If both therapist and patient can tolerate this regression to early dependence, the patient can perhaps be helped to repair some of the gaps and fragmentation in his being through experiencing more empathic care. A distant professionalism feels false and evasive: only a real person will do. As Winnicott put it:

> The borderline psychotic gradually breaks through the barrier that I have called the analyst's technique and professional attitude, and forces a direct relationship of a primitive kind, even to the extent of merging. (Winnicott 1960c)

Transitional Phenomena

Winnicott's theory of transitional phenomena (Winnicott 1971) is perhaps his most widely known idea. His ability to notice what was there to be seen brought into focus the rags, blankets and teddy bears to which young children are often almost addicted in their early years – an everyday aspect of young children's experience to which he was the first to give attention. Winnicott's thinking about these intense attachments developed in the context of childcare practices in post-war Britain, where the care of very young children was seen as the task of the mother alone. Babies experienced periods of excited and intimate contact, often around feeding, alternating with extended periods of solitude; they were normally weaned at around nine months. Children therefore had to cope with being alone on a regular basis, against a backdrop of intense involvement with one main

carer. Transitional phenomena are culture-specific, although Winnicott presents them as universal (Jacobs 1995: 105–7).

Transitional phenomena belong to the border between the child's early fusion with mother and his dawning realisation of separateness, in the area of transition between absolute and relative dependency. In this transitional zone, the baby finds he can use a particular object, sound, ritual or other happening as a way of managing his fears of being separate or alone. The transitional object is the blanket, rag or toy that the baby needs to be holding or sucking before he can go to sleep and which he may carry around for most of the day as well. The transitional phenomenon is a non-material object of attachment such as a song or story which plays the same role for the baby.

The transitional object or phenomenon is the emblem of the child's internal unity with a giving, accepting, nurturing mother. It is this security that the child grasps on to while struggling to let the mother go, both physically and in his acknowledgement that she is separate from him. It is for this reason that a child may need his transitional object more than he needs the actual mother to go to sleep with, or to help him manage his anxiety. It is the outward sign of the early blissful fusion between mother and child.

The separateness of the transitional object signifies the limits of the child's omnipotence: the rag or blanket is real rather than imaginary. The object's externality stands for the mother's externality, whilst its embodiment of the 'soul' of their felt unity softens this realisation. Through his transitional object, the child creates a resting place between the comforting illusion of oneness and the separateness that he can no longer deny. In his relationship with this special object he is allowed to have things both ways, and is usually intuitively supported in this by any adults or children he encounters. Teddy bears are often brought spoons and plates in restaurants and given seats on buses, yet never have to pay for food or fare. In numerous enthusiastic accommodations, adults who may not even be parents share this special transitional area.

Winnicott outlines the transitional object's essential features. It must belong to the child, and the child must be able to treat it as he likes; but at the same time, it must not be so malleable that the child feels he has magical control over it. The child's relationship with the object may range from identification to love and hate, and the object must survive the rough treatment of primitive relating. It must seem to have a substance and a life of its own to contribute to the relationship, whether through sound, texture, movement or

warmth. It must therefore be an external object or phenomenon – a blanket, toy, the sound of a musical box, shifting patterns on a rug – yet it cannot be copied or replaced. It carries its symbolic power only through the meaning with which the child infuses it.

The importance of the transitional object is that it both stands for and is not the mother. It is the beginning of symbol-making, of fantasy, play and thought. Winnicott places the start of transitional phenomena with purposeful vagueness, 'from four to six to eight to twelve months' (1971). Gradually, the child ceases to need a concrete embodiment of the transitional state as he becomes able to take both connectedness and autonomy for granted. The transitional object is not consciously given up, lost or mourned, but is slowly relegated to the margins, dropped behind a bed or left in a cupboard. The world now offers the child opportunities for broader transitional experience.

Winnicott suggests that we move beyond the single object to words, play, culture, art and religion as modes of experience which are not asocial but where we will not be challenged to account for our responses. In all these fields, the inner and outer worlds meet in a special area that is personal to each of us, and which offers particular meaning and enrichment to our lives. Yet even as adults we retain 'special' objects. The favourite mug, accustomed chair, the writer's pen, the musician's instrument carry rich feelings of kinship and intimacy which are logically spurious. They are relics of the fusion we originally felt with our earliest carer which we lovingly carry within us.

Winnicott describes the therapeutic setting as supremely transitional. The therapist offers himself and the therapeutic space explicitly for transitional experience. The client or patient responds most fruitfully by 'playing' with versions of reality, experiencing dependency, love, opposition, contempt and hate in a relationship which is tolerable through the patient's and therapist's knowledge that these reactions are not simply to be taken personally. Without play, Winnicott suggests, there can be no therapy; when the patient is enabled to play, growth and development naturally follow.

Deprivation and Delinquency

During the Second World War Winnicott acted as consultant psychiatrist to the British Government Evacuation Scheme in Oxfordshire, a post which involved the oversight of hostels set up

for those children who were too disturbed to be cared for in foster homes. He noticed that most of these children came from backgrounds in which family life was disrupted or inadequate or had broken down. He thus had an early opportunity to explore the links between early deprivation and later delinquency, as well as the related difficulties arising from the separation of children from their families. He retained an interest in this area throughout his working life, treating some such children directly or through family support as well as considering how society manages its delinquent and criminal members (Winnicott 1984).

Winnicott sees aggression not as a wholly separate instinct as did Freud and Klein, but as a part of relating which only becomes distinct from love over time. He suggests it is originally an aspect of the ruthless, self-seeking excitement of primitive relationship, before the realisation that the object of love is a separate and vulnerable being. It is only through the gradual relinquishing of the illusion of fusion and omnipotence that the child becomes able to consider the impact on the other of his own fierce desire. As the baby gathers together his myriad different feelings, impulses and perceptions of his mother, he builds an integrated view of two distinct yet connected people who are both loving and hating, lovable and hateable. He becomes able to make up for his anger and destructiveness through creativity and reparation, taking increasing responsibility for his own part in relationship. Winnicott (1963d) termed this achievement the 'stage of concern'; it is analogous to Klein's depressive position when this has become reasonably stable through the working through of depressive anxieties.

The baby's concern for himself and for the other can only develop in the context of a continuous personal relationship in which he is sufficiently protected from the primitive agonies of earliest life. Without the security and trust this builds, he will not risk moving beyond an illusion of omnipotence that will itself be over-strained. He will not have had the consistent arena in which he and mother could survive and sort out the intense contrasting states which make up a full relationship.

The child who has not experienced stable and continuous care will thus have far greater difficulty in building a coherent sense of self and integrating the different aspects of relating and relationship. He will have had neither the necessity nor the opportunity to realise the effects of both his anger and his love on the same person, and will not therefore appreciate their difference nor bring them together to develop an attitude of concern. He will not feel a part of the family,

group or society around him, and will not feel the obligation towards others that arises from this sense of belonging. This extreme circumstance is usually seen only in children who have been looked after by changing figures where close personal bonds have not had a chance to build up or have been continually broken. This was more common during the 1940s and 1950s than in the present day: the efforts of Winnicott and Bowlby mean that far fewer babies and young children are now brought up in impersonal and disrupted settings.

However, specific failure in relationship at the stage when the child is able to perceive his own separateness leads to a fault or gap in the development of the capacity for concern. Winnicott terms this failure 'deprivation', as opposed to 'privation'. It leads to an 'anti-social tendency', arising in the stage of relative rather than absolute dependence. Winnicott describes deprivation as the loss of good experience at a stage when the baby or child is able to perceive the loss as coming from the outside – usually from the parents. It is a loss which continues for longer than the child can manage, until his faith in his parents and in the world is broken. With this fracture, he is in danger of falling into a primitive agony of helplessness and inner collapse with no one to hold him together, and he tries to forestall this catastrophe by holding himself together and away from danger. He constructs a compliant self which is designed to fit in with a dangerous world, adapted to the external requirements rather than his own needs. Thus in the immediate wake of loss or disruption, a child may become unnaturally 'good'. Through inhabiting this 'false self', his 'true self' is protected; the price is a break in the continuity of living and relating from genuine need, love and anger.

The anti-social act or tendency emerges when the child becomes hopeful of a positive response from the world once more (Winnicott 1956, 1963f). His hope leads him to protest against his deprivation and try to put matters right. He may seek unconsciously to take back what has been 'stolen' from him in some form of stealing (often, of course, from the parents). He is reclaiming his right to take unreservedly from the other, as he did in the unconstrained good relationship he had before its traumatic break, and he is demanding that the other acknowledges his loss and makes amends in symbolic form as part of the re-establishment of a relationship of trust. Winnicott points out that many children have brief phases of demanding behaviour or actual stealing which is resolved through dependable loving care.

The anti-social tendency may also be expressed through destructiveness. The destructive act expresses not only anger but also a plea

for strong parenting from an adult who can contain and control the child without hate or vengeance. In meeting with a firm response from a loving adult, the child once more becomes able to trust the world to hold him: he no longer has to hold himself in anxious tension. When the child is convinced of the adult's ability to take responsibility for him, he can live once more from his true self rather than the defensive false self.

Most anti-social behaviour is held and resolved within ordinary family life. Parents often know intuitively when they should allow extra leeway for their child, realising that he needs love, reassurance and the relaxation of expectations. They respond spontaneously to his need to reach back to the time before his trust in the world was threatened, to 'make up' to the child for the difficulty he experienced, although neither child nor parent may consciously know what that was. Parents also know when they must provide their child with extra-firm limits for a time and not let him get away with anything. This consistent firmness is their attuned response to the child's need for the strong parent who will not allow the child's destructiveness to get out of hand, thus allowing him to relax.

The anti-social tendency is a response to trauma which may be temporary and insignificant or severe and continuous, but which follows on from good-enough experience. It is not a psychotic structure, because the child has some sense of differentiation of self and other. It can become part of a personality ranging from the near-normal or the neurotic, to the fragmented and near-psychotic.

It is a relatively straightforward task to manage a child whose anti-social tendency has arisen from minor deprivation in a generally reliable setting, but it is a different matter when the child or adult has become anti-social as a way of life. The extreme anti-social set-up is deep-rooted and compulsive and becomes more fixed and complex the longer it continues. When the child is almost overwhelmed by the original deprivation, his destructiveness may be a desperate playing-out of an intolerable inner state in an attempt to externalise it and get others to contain him. The less he feels this happens, the more frantically he continues in an escalating attempt to achieve safety. The confirmed delinquent, like the very young infant, may feel himself permanently on the edge of unbearable anxiety with persecution and disintegration barely kept at bay. His stealing and vandalism offer him some outlet, while challenging society to impose the control that he cannot. At an extreme, acts such as stealing, drug dealing or violence, together with society's controlling response, give an illusion, a parody almost, of emotional

satisfaction in a containing environment. This can become irresistible, especially when there is little opportunity for more wholesome satisfaction. The habitual criminal may have too much at stake to risk changing his ways. His delinquency gives him esteem from himself and his peers; it offers him a direction, even a career, in prison; and it gives him material goods through stealing, or an emotional buzz through excitement and power over others. With only despair, fragmentation and isolation underneath, giving these up is likely to be an unthinkable prospect.

With this in mind, Winnicott suggests that management should be differentiated from treatment in the area of delinquency and criminality. Treatment would be aimed at enabling the person to relinquish his anti-social defences, break down and experience being cared for in a way that would facilitate new growth on a basis of trust. This could only happen with strong motivation and excellent provision, and would involve the chaos of acute suffering. Management, on the other hand, is the structuring of the environment to take the place of the inner control the anti-social person lacks. In mild cases, this could be sufficient to help in the recovery of trust and connection, but the more dependent the delinquent is on external control, the more such control has to be a holding operation rather than a strategy to encourage change of anything deeper than behaviour. The less the person can make use of personal relationship, the more impersonal and strict management has to be. Within a regimented environment, the deprived person may feel sufficiently secure to experience a reasonable quality of life. With a relaxation of control, the unbearable agony will surge forth again, leading to renewed offending behaviour which ensures relief from internal pressure and the re-establishment of control from the outside.

For these reasons, Winnicott believed that some apparently rigid and Spartan régimes are effective and humane responses to some extremely anti-social delinquents. He points to the danger, now not uncommon within the care system, of the continued breakdown of deprived children's placements in potentially loving foster homes. The intimacy and flexibility offered to some frightened and angry children may seem threatening and not sufficiently containing, leading to a further breakdown of inner control. In this situation, an escalation of destructiveness may be less a sign of hope than an externalisation of inner disintegration and a desperate attempt to find more effective external control. Even if such a child does respond with hope to the possibilities of the new setting, his 'testing-out' is liable to be extreme. Whatever the mixture of hope and desperation, the ensuing manipulations, lying, stealing, destructiveness and violence may well be too much for the foster family to bear. All too often, such placements continue to break down until the security of a young offenders' institution is reached, followed by a graduation to prison.

Winnicott's views on deprivation and delinquency led him to disagree sharply with Bowlby. Bowlby's work on the far-reaching effects of maternal deprivation persuaded him to press for children to be kept with their own parents if at all possible, and for those who had to be taken into care to be placed in foster homes rather than institutions. This led to the closure of many children's homes in what Winnicott felt to be a decreasing appreciation of the needs of the most disturbed delinquent children.

Winnicott's view of delinquency has been highly influential. Parents and teachers are now more understanding of the unhappiness that often lies behind the brief phases of attention-seeking, disruptiveness and stealing through which many children pass. Judicial systems may still be mindful of the need to keep young delinquents from becoming confirmed criminals, often advocating social intervention rather than institutionalisation in a fixed anti-social community. However, the backlash against liberalism in recent years has turned against understanding towards incarceration and revenge. Winnicott spoke of punishment as largely irrelevant to the confirmed offender, but necessary to society. Systematised social retribution allows society to forgo the brutality of spontaneous vengeance in favour of a vicarious, controlled expression of hurt and anger. The urge for some form of retribution can provide the motivation to maintain and fund régimes which are sufficiently rigid for offenders to feel safe within. Winnicott might have suggested that this swing could have arisen in part from the overlooking of some delinquents' needs for strong control, as well as the inadequate recognition of society's needs.

Commentary

Winnicott is a maverick figure in psychoanalysis. His practice and his writing express a relational depth which encompasses the worlds of medicine and psychoanalysis, parenting and professionalism. As a psychoanalyst he brought an imaginative and creative optimism to the oppressive and pathologised Kleinian scenario. He did not revise the theoretical structures of Freud or the conceptual

developments of Klein, but he used their work as a background for a new emphasis on the role of the environment in emotional development. Winnicott's psychoanalysis is art as well as science, requiring empathy as well as thought. He values emotional closeness, the capacity for relaxing personal boundaries and an imaginative and playful attunement to others. Marilyn Senf (1995) sees Winnicott's work as a growth of the feminine in psychoanalysis. The intimacy of his thinking, working and writing lends a refreshing intersubjectivity to the individualistic focus of Freud and Klein.

Winnicott's aim was very similar to that of Klein: 'I'm going to show that infants are ill very early, and if the theory doesn't fit, it's just got to adjust itself' (Winnicott 1989: 575). Like Klein, he had to place his ideas in relation to existing theory, a task which he carried out half-heartedly.

Winnicott differs from Freud in his practical and theoretical dependence on a relational rather than a mechanistic approach, and from Klein in his view that the environment is as crucial as instinct in emotional development. Yet he does not wholly abandon instinct theory, and he presents his ideas as built on Freudian foundations with only minor divergences from Kleinian theory. Goldman (1993: 137) brings out Guntrip's view that Winnicott maintained a dual relationship with Freud, disagreeing in private while upholding him in public. His sharp criticism of Fairbairn – 'He spoils his good work by wanting to knock down Freud' (quoted in Guntrip 1975) – demonstrates a powerful aversion to the overthrow of forebears, despite his declared independence of mind. His unwillingness to criticise both Freud and Klein may be partly rooted in his affectionate regard for them; together with Darwin, they were the foremost influences in his thinking. It also conforms with the conservatism of much of his world view and brings to mind his fear of opposing his father's wishes.

Greenberg and Mitchell suggest that Winnicott's unwillingness to oppose Freud and Klein results in muddled theoretical premises. They point to his subtle and gross misrepresentations of major aspects of Freudian and Kleinian concepts:

> He recounts the history of psychoanalytic ideas not so much as it developed, but as he would like it to have been, rewriting Freud to make him a clearer and smoother predecessor of Winnicott's own vision. (Greenberg and Mitchell 1983: 189)

They suggest that while his practice and the main thrust of his theory are relational, he maintains a spurious allegiance to drive theory: his ideas imply a dual track in development, presenting both biological urges and the search for meaning as primary.

The underlying premises of Winnicott's work are indeed ambiguous. He uses Freudian language and concepts, but alters some of their main properties without saying that he is doing so. The following passage, for example, gives no indication that he is using the term 'id' idiosyncratically to denote a particular type of bodily experience, rather than as the forever unconscious source of instinctual life:

> *Example:* a baby is feeding at the breast and obtains satisfaction. This fact by itself does not indicate whether he is having an ego-syntonic id experience or, on the contrary, is suffering the trauma of a seduction, a threat to personal ego continuity, a threat by an id experience which is not ego-syntonic, and with which the ego is not equipped to deal. (Winnicott 1960d)

Winnicott is suggesting that there are two strands in human development which only come together partially and gradually. On the one hand there is the personal strand of meaning and relationship, articulated with particular clarity and commitment in his account of true- and false-self development (Winnicott 1960b). On the other, there is the impersonal strand of bodily instinct which he relegates to secondary status but which he does not incorporate within the relational stream.

Winnicott views the ego as synonymous with the person, in that it is meaningless to speak of development without the assumption of an experiencing person. 'Is there an ego from the start?' he asks; and answers himself, 'The start is when the ego starts'; adding rather cryptically, 'It is as well to remember that the beginning is a summation of beginnings' (Winnicott 1965: 56). He gives an example of an infant born with much of the brain missing whose physiological functioning cannot be called ego-functioning because the infant has no capacity for experience. He thus gives relative primacy to ego development and subjectivity over instinctual development and biology, because it is the experiencing ego that renders the organism human.

This leads Winnicott to conceptualise 'id experience' as a factor which is external to the ego (the 'I'); and it is only when the ego has developed some resilience that instinctual demands can be a confirmation of personal identity rather than a threat to it. The

'instincts' resulting in 'id experience' are somatic urges which have a quality of seeking climactic relief, such as hunger, sexual excitement, the wish to move or the need to defecate. While the ego is still fragile, they may be felt to impinge on the baby's sense of cohesion and identity. It is therefore part of the mother's role to manage the infant's bodily states in an emotionally attuned way. Satisfactions such as being fed or touched can be experienced by the infant as 'seductions' in which his personhood feels overlooked, while his physical need and excitement are exploited:

> It is indeed possible to gratify an oral drive and by so doing to *violate* the infant's ego-function, or that which will later on be jealously guarded as the self, the core of the personality. (Winnicott 1962b)

Winnicott thus sees human development as arising from both object-seeking and gratification-seeking roots, a view he shared with Balint and which formed the basis of his rejection of Fairbairn's theoretical structure. He differentiates between ego experience which is concerned with meaning and relationship, and id experience which he seems to view as without meaning until it has become integrated with ego experience. However, his use of such terms as 'id experience' makes clear that instinctual life is only relevant insofar as it is experienced. This appears to undermine his dual view: if instinct can be incorporated within experience, his theory is founded on subjectivity rather than both drive and subjectivity. While experientially evocative, his formulations involve a theoretical confusion which he does not explore.

Winnicott's rejection of the death instinct is also problematic. He suggests that aggression is part of primitive loving and cannot be seen as destructive, being more akin to energetic assertion. He thought the death instinct was a psychoanalytic version of original sin, entailing a condemnation of the infant to which he was wholly opposed. However, he also suggests that aggressive impulses are initially separate from erotic impulses: he speaks of the 'erotic root' and the separate 'aggressive root' of instinctual life (Winnicott 1950–55). Taking up the Freudian idea of the fusion of the death instinct and Eros, he postulates an early stage of 'pre-fusion', when aggression and desire form distinct relational components. 'Fusion' is a psychological task which is closely related to the development of the capacity for concern. 'De-fusion' arises from the de-integration of love and hate in a partial or total breakdown of the capacity for concern.

If the desiring and aggressive components of object relating have separate roots and are brought together in a progressive integration, Winnicott's objection to the death instinct seems unfounded. A change of name, differentiating assertiveness from destructiveness, would seem more apt than an abandonment of the concept.

Winnicott's assumption of the initial merged state of the infant with the 'environmental mother' presupposes a position prior to Klein's paranoid-schizoid position. It was an assumption Freud also held in his view of primary narcissism, and which Klein and Fairbairn relegated to pre-natal life. The widespread assumption that early development involves individuation out of initial fusion is questioned by Stern (1985), who offers evidence for the merged state being a mode of relating that becomes possible after, rather than before, the differentiation of self and other. He suggests that infants are other-oriented from birth, with the sense of self and other emerging from nothing, rather than from a prior sense of unity. His comparison of research findings with psychoanalytic assumptions calls for a wholesale review of common psychotherapeutic views of early development. This material was not available to Winnicott, and he commented that it was easier to track early developmental processes through regressed patients than through direct observation of infants and parents. It is thus quite possible that his assumptions of merging and differentiation are over-simplified or wrongly ordered.

The unstated contradictions underlying Winnicott's ideas have been treated variously as pedantic, off the point or as evidence of a lack of systematic thinking. Winnicott is regarded by some as a visionary who writes poetically rather than analytically. The evocative power of his self-expression does indeed create in the reader an experience of the concept or the sense he is describing, whether this is the transitional area, the primitive agonies, a patient's state of mind, or even id experience. He is one of the most vividly communicative of psychoanalytic writers. Nevertheless, his declared allegiance to scientific method rather than creative expression alone means that the premises on which his creativity rests cannot be ignored.

Winnicott's detractors point to the lack of rigour in his theoretical structure, suggesting that this was paralleled by an overly indulgent attitude to patients. Guntrip made the suggestion that Winnicott, though 'clinically revolutionary ... [was] not really interested enough in pure theory to bother to think it out' (quoted in Goldman 1993: 137). Winnicott endorsed this impression at times by presenting himself,

to the delight of his audience, as the charming, creative, naughty child who neglects to go through the literature or acknowledge his sources. His colleague Masud Khan recounts how he urged Winnicott to read a newly published book; his friend expostulated: 'It is no use, Masud, asking me to read anything! If it bores me I shall fall asleep in the middle of the first page, and if it interests me I will start re-writing it by the end of that page' (Winnicott 1975: xvi). Khan was responsible for much of the editing and preparation of Winnicott's writing, and prodded him to relate his ideas to those of others (Winnicott 1965: 11). Winnicott was particularly anxious about reading the work of Ferenczi, an early exponent of a relational approach to psychoanalysis, because of his fear that he would find his own ideas there; and in an informal talk he gave to his colleagues near the end of his life, he conceded with some humility that he had been remiss in his failure to correlate his ideas with theirs and acknowledge their contributions (Winnicott 1967b).

To condemn Winnicott as lazy and self-indulgent in his thinking seems no more adequate than it would be as an assessment of a patient. More enlightening are the numerous indications that Winnicott lacked confidence in himself as a thinker. The brevity of many of his papers suggests a nervousness about holding and developing a theme. Goldman, quoting various letters, draws out the sense of intellectual inferiority which hampered him in discussions with colleagues, and even 'inhibitions in regard to the reading of Freud' (Goldman 1993: 146). Winnicott joked about his headmaster's estimation of him: 'Not brilliant, but will do' (Winnicott 1989: 11), but it was a remark he always remembered. His dread of opposing or disappointing his benignly painted father may be a demonstration of his fear of competition; and it is interesting to learn that his father was himself sensitive about the learning difficulties that had hampered his education (Jacobs 1995: 3). Winnicott's capacity for lateral thinking, and also his symptom of following words in his throat, could well relate to specific learning difficulties, often subsumed under the term dyslexia; no doubt his father suffered from such specific difficulties and Winnicott may also have done so subliminally or through identification with his father. It would thus not be surprising if Winnicott played to what he felt were his creative strengths, rather than his intellectual weaknesses.

Winnicott's theoretical work may be re-evaluated by relating it directly to its context of Freudian and especially Kleinian dominance. While both he and Klein focused on the earliest stages of life with their primitive mental processes, Klein emphasised unconscious

phantasy, aggression and the role of the instincts in emotional development. Winnicott, by contrast, speaks of his wish to balance Klein's emphasis with an intelligent attention to the effects of the environment.

This suggests the possibility of reading Winnicott as one component in a Winnicott–Klein conjunction. Seeing Kleinian theory as Winnicott's split-off pessimistic aspect, and even Winnicott's work as Klein's split-off optimistic aspect, may enhance both contributions. Winnicott's dismissal of the death instinct as unnecessary makes sense if his role was to provide a balancing additional focus; and the 'external' and seemingly contentless instinctual impingements he mentions can be recast as Klein's unconscious phantasies, the mental corollaries of instinct projected out because of the internal threat from the death instinct. His optimistic view of delinquency as a sign of hope, his cosy picture of nuclear family life and the well-being of Western society, could represent a necessary part of a larger picture balanced by Klein's grim internality and individualism. His conviction that the core of the self could never be reached from the outside is perhaps a rare glimpse of the essential isolation he shared with Klein. The increasing distance that grew up between Klein and Winnicott reveals the difficulty each had in accepting the theoretical mode of the other, despite personal liking and an early mutual feeling of affiliation. The position held by each may have been emotionally repugnant to the other.

The beguiling simplicity and immediacy of Winnicott's work bring a subtle challenge to his readers. He gives us every encouragement to take a one-sided view of his unusual contribution by idealising him and his theory, or conversely by dismissing it. By insisting on a more rigorous evaluation we might gain more than he realised he was giving: a structural expansion to theory which enhances his inspired creativity.