infant’s negative affect, the perception of a corresponding realistic negative emotion in the parent will escalate the baby’s negative state, leading to traumatization rather than containment (Main and Hesse 1990).

This constellation corresponds to the clinical characterization of projective identification as a pathological defensive mechanism characteristic of borderline personality disorder (Kernberg 1976; Klein 1946; Sandler 1987; H. Segal 1964). Therefore, it can be hypothesized that sustained experience with categorically congruent but unmarked affect-mirroring in infancy might play an important causal role in the establishment of projective identification as the dominant form of emotional experience in borderline personality development.

2. Lack of category congruence. A second type of deviant mirroring structure might be produced by the dominance of marked, but incongruent, categorically distorted parental mirroring. Over-controlling parental attitude and/or defensively distorted parental perception of the infant’s affect may produce a mirroring style of this sort. Think of an infant whose erotically colored excitement about physical contact induces anxiety and defensive anger in the mother due to her intrapsychic conflicts in relation to bodily tenderness. The mother might project her defensive emotional reaction onto the infant, as a result of which she will distortedly perceive the baby’s libidinal excitement as aggression. She may then proceed to modulate this thus misperceived affect in her baby by properly marked mirroring of an aggressive display.

According to the present hypothesis, marked but categorically distorted affect-mirroring of this kind, when dominant in the infant’s experience, may lead to the following consequences: (a) Due to the markedness of the mirrored affect, it will be decoupled from the parent. (b) As the mirroring display shows a sufficiently high degree of contingency with the infant’s—mis-categorized—affect state, he will referentially anchor the mirrored affect-display to his primary emotion state. (c) However, since the category of the mirrored affect is incongruent with the actual affect state of the infant, he will establish a distorted secondary representation of his primary emotion state. As a result, the infant will attribute dispositional information to himself that is incongruent with his actual (primary) emotion state, leading to a distorted perception of his self-state.

Thus, one may speculate that marked, but categorically distorted, incongruent mirroring of affects might be causally related to categorically distorted self-representations, which may, for example, underlie sexual pathologies in which libidinal excitement is perceived as aggression.

This type of deviant mirroring provides a link between our model and Winnicott’s concept of the false self. According to Winnicott (1960a), impingements from the environment may arise out of the caregiver’s difficulty in understanding the infant’s thoughts or feelings, substituting her gestures instead of representing his own intentional state to the baby, invalidating the gestures, and obstructing his illusion of omnipotence. When this continues despite persistence by the infant, Winnicott suggests that a number of reactions can arise: the self may be overwhelmed, it may become anxious anticipating further impingement, it may come to experience itself only when it acts in opposition to impingements, and, finally, it can acquiesce and hide its own gestures, undermining its own ability. In this latter case, Winnicott assumed, the self ends up mimicking its caretaking environment, resigned to the deficiency, setting aside creative gestures, and perhaps even forgetting they ever existed.

Winnicott suggested that the infant complacently relates to the caregiver’s gestures as if they were his own, and this compliant stance lies at the root of the false-self-structure. It follows from Winnicott’s view of the hallmarks of the true self that the false self is revealed by a lack of spontaneity or originality. It also follows from his understanding of how false-self-structure originates that such individuals later seek out external impingements to recreate the experience of compliant relating and, with it, a sense of realness about their own existence. Winnicott also identified the kind of self that appears to be real but is built on identification with early objects and thus lacks something uniquely its own.

Winnicott described how the false self may sometimes act itself up as real and generally convey this impression to others, but it does so mechanically, lacking genuine links between inter-
The distinction is critical in our understanding of self-related and parental influences on development. The self-concept is shaped by experiences that are internalized by the child and modified by feedback from others. The concept of the self is a dynamic and evolving construct that is influenced by various factors, including biological, psychological, and social variables.

In the context of attachment theory, the self-concept is developed through interactions with caregivers. Research on infant attachment has shown that secure attachment patterns are associated with the development of a positive self-concept. Securely attached infants are more likely to develop a sense of competence and self-worth, while insecurely attached children may have more difficulty forming a positive self-image.

The role of caregivers in shaping the self-concept is significant, as their attitudes and behaviors can influence the child's perceptions of themselves. For example, parents who provide consistent and supportive care are more likely to foster a positive self-concept in their children.

In summary, the development of the self-concept is a complex process influenced by a variety of factors. Understanding the role of self-related and parental influences is crucial for early intervention and support, particularly for children who may be at risk for developing negative self-concepts due to adverse experiences.

In the context of therapeutic interventions, the goal is to help children develop a more positive self-concept by providing them with positive feedback and support. This can involve improving the child's self-esteem, teaching coping strategies, and addressing any underlying emotional or behavioral difficulties.

Ultimately, the development of a healthy self-concept is essential for children's overall well-being and success in school and in life. Early intervention and support can significantly impact a child's ability to develop a positive self-concept, setting them on a path for continued growth and success.