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2011-04-26
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A critical examination of Bion's concept of containment and Winnicott's concept of holding, and their psychotherapeutic implications

by

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Declaration:

A research project submitted in partial fulfilment of the requirements for the degree of MA by Coursework and Research Report in the field of Clinical Psychology in the Faculty of Humanities, University of the Witwatersrand, Johannesburg, Republic of South Africa, 22nd November 2010.

I declare that this research project is my own, unaided work. It has not been submitted before for any other degree or examination at this or any other university

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Word Count: 18 990

Abstract:

Wilfred Bion's concept of the container/contained and Donald Winnicott's concept of holding are two concepts that have had a profound influence on the development of psychoanalysis over the last half century. They are frequently used interchangeably in the literature and are often seen as denoting essentially the same clinical practice. It is the author's contention that there are substantial differences between the two concepts and the models of mind that underpin them, and how they are translated into clinical practice. The models of mind and developmental trajectories that underpin the concepts of containment and holding are explicated fully, demonstrating some of the clear differences between the foundations of these two concepts. Further, through the use of clinical vignettes, the substantial differences between holding and containment in clinical practice were elucidated.

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Chapter 1 - Introduction:

Wilfred Bion's (1962b) concept of the "container/contained" and Donald Winnicott's (1945) concept of "holding" are both concepts that foreground the role of the mother in the developmental trajectory of the infant and, furthermore, they are both constructs that have found significant purchase in the clinical setting. Indeed, as with much psychoanalytic theory, the developmental theories that underpin these concepts were forged in the clinical setting - Bion (1957; 1959) and Winnicott (1947) both used their experiences of particular groups of patients to extrapolate back to the processes of infancy. At first glance, there appear to be many similarities between the two concepts, and this has often led to them being conflated and confused in the literature (e.g. Wright, 2005; Rustomjee, 2007). However, it is my belief that there are substantial differences between the concepts of holding and containment and the models of mind that underpin these two concepts, and that to use them interchangeably is to reduce theoretical precision and to increase confusion in the clinical setting. Given the influence that both concepts have had on the theory and practice of psychoanalysis over the last fifty years, then it would seem prescient that a detailed evaluation of them as developmental theories and clinical practices be conducted.

There are relatively few comparisons of holding and containment in the literature, and what few there are (Symington & Symington, 1996; Caper, 1999; Ivey, 2009) tend to give the comparison a fairly short treatment. Symington & Symington (1996), in their work on Bion, differentiated between the two concepts in three ways. For them, the container is an internal phenomenon with holding (or the holding environment) occurring externally or in "the transitional stage between internal and external" (Symington & Symington, 1996: 58).They also see holding as a more sensuous activity that is generally positive and growth enhancing, whereas containment is seen as non-sensuous and "may be either integrating or destructive" (Symington & Symington, 1996: 58). However, one is left with more questions and answers from this comparison - firstly, they don't appear to specify whether they are talking about the two concepts in the context of the mother and infant or in the clinical setting. Presumably, in describing the holding that occurs as 'sensuous', they must be referring to the interaction between mother and infant, although Winnicott was inclined to hold his patient's hand from time to time (Spurling, 2008). In his comparison of holding and containing Ivey (2009) appears to take issue with Symington & Symington's (1996) assertion that containing is non-sensuous, where he states that while the "core reverie phase [in containment] involves meaning-

making, rather than sensory-physical handling", the "end-stage of containing will involve some appropriate physical activity based on the mother's understanding of her infant" (Ivey, 2009: 119). However, Ivey (2009) appears to concur with Symington & Symington's (1996) contention that holding is essentially positive while the container/contained relationship may be destructive. One of the major differences that Ivey (2009) sees between the two concepts is that, for him, the "Bionian baby has an innate awareness of his mother as something beyond or outside himself" whereas the "Winnicottian baby needs to feel initially that his mother is an extension of him, and hence not separate from him" (Ivey, 2009: 119). As we will see in later chapters, this is a key distinction between the two models of infantile development and will be explored in detail with an emphasis on the differences that this introduces into clinical practice. Caper's (1999) description of the difference between holding and containing focuses exclusively on clinical practice and sees holding as a stage in the containment process that allows the therapist to convey to the patient that he is able to see things from the patient's point of view. Caper (1999: 154) believes that containment then goes one step further by interpretations which identify the analyst as an "object that the patient experiences as distinct from himself". Thomas Ogden's (2004) paper on holding and containing represents one of the longest treatments of the two concepts in the literature. However, he portrays the concepts one after the other at the expense of actively teasing out the points of difference, leading him to conclude that they "represent difference analytic vertices from which to view the same analytic experience" (Ogden, 2004: 1362). It is my contention that the 'analytic experience' as described by containing is *very* different to that described by holding, that it is not merely a case of viewing the same process from different perspectives as Ogden (2004) would have it. After all, in their paper on conceptual research Leuzinger-Bohleber and Fischmann (2006) have asserted that "all concepts and theories have an influence on perceptions and observations in the clinical situation and—at the same time—'good, innovative and flexible' theoretical understanding is constantly influenced by clinical experience" (Leuzinger-Bohleber & Fischmann, 2006: 1360). In other words, it is problematic to claim that holding and containing represent essentially the same analytic experience when the theoretical foundations that support and invigorate both of the concepts are so different.

To this end, this research report will provide a detailed elucidation (drawing, as far as is possible, from the original writings of Bion and Winnicott) of the models of mind that underpin and the developmental trajectories suggested by each of the two theories. Chapter 2 will give a detailed description of Bion's concept of the container/contained as it applies to the developmental setting - this focus enables us to clearly explicate the model of mind that Bion developed. I have drawn on

Bion's (1957; 1959; 1962a; 1962b; 1963) earlier work in the chapter below as it is in these works that the concept of the container/contained finds it's earliest and clearest explication. Chapter 3, in turn, provides a detailed account of Winnicott's concept of holding and, as with the previous chapter on Bion it is an account located in the very early stages of infancy and the relationship between mother and child. In contrast to Chapter 2, Chapter 3 will draw on a wide array of Winnicott's original writings as I believe that a fuller understanding of his concept of holding is garnered through an extensive appreciation of his work. In both of these chapters, the focus on the early relationship between the caregiver and infant allows us to flesh out the respective models of mind underpinning the concepts in an uncluttered way. Having the two concepts elucidated side by side then prepares us for Chapter 4 where, in the first section, the similarities and differences between the two developmental concepts are drawn out. In the second part of Chapter 4, the transition is made to comparing the two concepts in clinical practice, this is achieved through the use of clinical vignettes drawn from the literature. It was difficult to find clinical material of suitable length and detail in the work of both Bion and Winnicott that suited the purposes of this research report, so instead material was drawn from the work of Masud Khan (1960) and John Steiner (2000). Khan's (1960) extremely lengthy depiction of regression and therapeutic holding is explicitly faithful to the theories of Winnicott and provides ample material to demonstrate holding in the clinical context. Steiner's (2000) clinical vignette is significantly shorter than Khan's (1960), but its stated intent is to demonstrate the complexities of the container/contained relationship in the clinical milieu and is used as such. In Chapter 5 I take the two vignettes used in the previous chapter and apply the concept of holding to Steiner's (2000) vignette and containment to Khan's (1960).While this is obviously a speculative exercise, it provides a focal point for highlighting the substantial differences between the application of the two concepts in clinical practice. Chapter 6 draws together the strands from the previous chapters and makes some concluding remarks.

Chapter 2 - Bion's Developmental Theory and Model of Mind

We now turn our attention to the genesis of the concept of containment in the work of Wilfred Bion. Through a consideration of the influence that Melanie Klein had on the work of Bion and a charting of how his work evolved into something that Klein might have battled to recognise, we will attempt to tease out the salient features of the developmental theory and model of mind that buttresses his concept of the container/contained. Melanie Klein's (1946) concept of projective identification can be seen, in many respects, as the germinating force behind Bion's development of his theory of the container/contained. Klein's concept of projective identification has been seen by some (O'Shaughnessy, 1981) as an elaboration of Freud's (1911) elucidation of the aims of the pleasure principle. The most profound difference that Klein (1946) introduced in her theory, and the one that was most fruitfully elaborated upon by Bion, was that she saw projective identification by the infant not merely as an attempt to rid itself of unpleasure (with little regard as to its final destination), but as an attempt to project the intolerable fragments "*into* the mother" (Klein, 1946: 183). However, it is worth noting at this point that Klein clearly believed that projective identification took place in the phantasies of the infant/patient and that, for her, it was never a question of the patient/infant being able to "literally put things into the analyst's [mother's] mind or body" (Bott Spillius, 1992: 61). It is worth quoting Klein at length here to stress a point that has implications for our later comparison between Bion and Winnicott's respective models of mind:

> "These excrements and bad parts of the self are meant not only to injure but also to control and to take possession of the object. Insofar as the mother comes to contain the bad parts of the self, she is not felt to be a separate individual but is felt to be *the* bad self" (Klein, 1946: 183).

So, implicit in what Klein is saying is that the infant is born into this world with a sense (albeit vague) that there is a distinction between self and object and, more explicitly, that the use of projective identification to expel bad parts actually serves to blur this distinction.

Paula Heimann (1950) and Roger Money-Kyrle (1956), through their work on the nature and uses of the countertransference, deepened the understanding of projective identification as first laid out by Klein and it was from within this context that Bion began to develop some of his ideas further (Cartwright, 2009). Like many psychoanalytic theorists Bion developed his theories through clinical

practice, and his development of the 'container/contained' is no exception – more specifically, it evolved out of his work with psychotic and borderline psychotic patients (Britton, 1992). Bion believed that the psychotic mind was constituted differently to the non-psychotic mind, and that the psychotic mind was dependant on the "minute splitting of all that part of the personality that is concerned with awareness of internal and external reality, and the expulsion of all these fragments so that they enter into or engulf their objects" (Bion, 1957: 61). In his paper 'Neurosis and Psychosis' Freud (1924) put forward the idea that "in the psychoses the...ego in the service of the id, withdraws itself from a part of reality" (Freud, 1924). Bion (1957) develops Klein's thoughts on projective identification quoted above to fashion a modification of the traditional Freudian view espoused above asserting that he does not believe that "the ego is ever wholly withdrawn from reality. I would say that its contact with reality is masked by the dominance, in the patient's mind and behaviour, of an omnipotent phantasy that is intended to destroy either reality or the awareness of it" (Bion, 1957: 64). In that last part of this quote we can see a subtle elaboration of the thought of Klein, an indication that Bion saw in projective identification not merely an attempt to rid the psyche of accretions of 'badness', but something resembling the apparatus for awareness. Admittedly, he is talking about psychotic patients in this instance but it adumbrates some of his ideas on thinking which were to find fuller voice in later papers. He goes on to assert in this landmark paper that "some kind of thought, related to what we should call ideographs and sight...exists at the outset" (Bion, 1957: 66). So, Bion posits the capacity for rudimentary thought at the outset of life in this paper but he stops short of describing how this goes on to develop and complexify in health, choosing instead to focus on how excessive projective identification can hinder this process.

In his paper 'Attacks on Linking', Bion (1959) takes the concept of projective identification and the idea of the infant possessing a capacity for rudimentary thought, and makes more explicit the link between the two. When discussing the relationships of the paranoid-schizoid position, he has this to say:"the part-object relationship is not with anatomical structures only but with *function*, not with anatomy but with physiology, not with the breast but with feeding, poisoning, loving, hating" [my emphasis] (Bion, 1959: 94). The mechanism that Bion (1959) saw playing a pivotal role in this relationship was projective identification, and by highlighting the functional nature of the relationship he paved the way for a consideration of the role of projective identification in normal development. In this paper, ostensibly about the symptomatology of borderline psychotic patients, lie the building blocks of all of his later work on the pathways of normal development. By positing the idea of 'normal projective identification', Bion (1959) broadened the emphasis inherent in Klein's

(1946) exposition of the idea of 'excessive projective identification' with its focus as a primitive defence. Paradoxically, it is through an interaction with a highly pathological patient that Bion (1959) is able to pinpoint the important dynamics of normal development, showing that "when the patient strove to rid himself of fears of death which were felt to be too powerful for his personality to contain he split off his fears and put them into me, the idea apparently being that if they were allowed to repose there long enough they would undergo modification by my psyche and could then be safely reintrojected" (Bion, 1959: 96). Bion then rewinds this process back to the patient's infancy, showing that this patient would have had more chance of attaining a measure of normal development if his mother could "have taken into her, and thus experienced, the fear that the child was dying. It was this fear that the child could not contain...an understanding mother is able to experience the feeling of dread, that this baby was striving to deal with by projective identification, and yet retain a balanced outlook" (Bion, 1959: 96-97). It becomes clear in reading this paper that Bion no longer saw projective identification as a phantasy (in the mind of the individual) with a more traditional straight line shape where fragments were expelled defensively into objects, what starts to emerge is something involving two psyches where projective identification is part of a process that describes a more parabolic course – fragments are ejected as a means of communication and so that they can be investigated in a personality strong enough to contain them (Bion, 1959), for eventual repossession at a more opportune time.

There is a clear emphasis on clinical practice evident in Bion's two major papers of the 1950's, 'The Differentiation of the Psychotic from the Non-Psychotic Personalities' and 'Attacks on Linking', but what also emerged was the suggestions of a distinct model of mind. It was a model of mind that was recognisably different from a Kleinian matrix and one that had taken some distinctive steps forward in its elaboration of her theories (Ferro, 2005). Bion's (1962a) paper, 'A Theory of Thinking', appears to be an attempt to delineate this model of mind in a format uncluttered by excessive amounts of clinical material, an attempt to describe the place where the evolving currents in his work had caused his ideas to fetch up. Fairly early on in this landmark paper, Bion asserts the essential uniqueness of the position that he has arrived at when he says that "thinking is a development forced on the psyche by the pressure of thoughts and not the other way round", and goes on further to say that "psychopathological developments may be...related to a breakdown in the development of thoughts, or a breakdown in the development of the apparatus for "thinking" or dealing with thoughts, or both" (Bion, 1962a: 179). From this broad opening he goes on to more specifically define how thoughts can be classified into pre-conceptions, conceptions, and concepts and Bion

(1962a) saw it playing out in the following way: in a situation where a pre-conception (the example that he uses is the infant's expectation of the breast) "is brought into contact with a realization that approximates to it, the mental outcome is a conception" (Bion, 1962a: 179) and he also asserts that these conceptions will be constantly linked with an emotional experience of satisfaction. Bion (1962a) believes that thinking develops in a situation where a pre-conception (let's say expectation of the breast again) comes up against the realization that there is no breast available to provide satisfaction – if the infant is able to sufficiently tolerate frustration then this absence becomes a rudimentary thought (i.e. a representation of the breast in its absence) and the apparatus for thinking these thoughts begins to develop in the infant's internal world. This apparatus is linked to what Klein (1930) had to say about symbol formation, where she says that without the capacity to symbolise the infant has no substrate from which to generate phantasy and from which to sublimate - hence the infant is robbed of a means of tolerating anxiety. One can see in this paper the profound influence that Klein had on Bion where, while describing how it is vital that the inchoate ego be able to tolerate anxiety, she asserts that "a sufficient quantity of anxiety is the necessary basis for an abundance of symbol formation" (Klein, 1930: 98). This influence can be seen in Bion's formulation quoted above: it is in the absence of the breast that a rudimentary thought develops. So, the ability to think (or form symbols) cushions the blow of the unpredictable and varied frustrations that make up the infants world – psyches that are able to tolerate some frustration are able to use this capacity to differentiate between self and object, the symbol is more clearly distinguished from the object and can be used more freely (to make reparation, for example) and is thus better equipped to provide coherence to the infants internal world (Segal, 1955). In psyches that struggle to tolerate frustration and are more intent on evading it, what develops is a bad object "indistinguishable from a thing-in-itself" (Bion, 1962a: 180) that cannot be 'thought' about and thus made sense of and is only fit for evacuation through excessive projective identification. This 'thing-in-itself' can be seen as similar to Segal's (1955) idea of the 'symbolic equation', where the symbol is taken for the object itself, where the concrete rigidity of it can allow only one defence: expulsion through projective identification. In this emphasis Bion does not stray too far from the ideas of Freud and Klein, the notion that tolerated frustration is the great invigorator of development (Davison, 2002). At first glance, Bion's (1962a) model for normal development appears simple and static: the infant either has the capacity to tolerate the frustration or not, the mother can either provide good experiences or not. But Bion complexifies this as the paper develops, showing it to be a cyclical process where the conception formed becomes the pre-conception that seeks the next realization, and that in health a "conception does not necessarily meet a realization that approximates sufficiently closely to satisfy. If frustration can be tolerated the mating of conceptions and realizations whether negative

or positive initiates procedures necessary to learning by experience" (Bion, 1962a: 181). What he is saying here is that there is seldom a perfect fit between what the infant wants (or what it is trying to communicate) and what it receives but that if the infant can tolerate the frustration in this process, then experience slowly provides the building blocks for thinking and helps give the infant's developmental trajectory momentum. Bion (1962a) makes it clear that this process of thinking should not be confused with the defences of intellectualisation and omniscience, putting forward the notion that "omniscience substitutes for the discrimination between true and false a dictatorial affirmation that one thing is morally right and the other wrong" (Bion, 1962a: 181). So, implicit in this is the assumption that while something can be ruminated about in words and in terms of wrong and right, if it is divorced from the emotional links that underlie experience then the individual's ability to decide between true and false is compromised. It is worth quoting Bion at length from the end of this paper, as in this quote are all of the fundamental elements of the container/contained relationship:

> Normal development follows if the relationship between infant and breast permits the infant to project a feeling, say, that it is dying into the mother and to reintroject it after its sojourn in the breast has made it tolerable to the infant psyche. If the projection is not accepted by the mother the infant feels that its feeling that it is dying is stripped of such meaning that it has. It therefore reintrojects, not a fear of dying made tolerable, but a nameless dread. (Bion, 1962a: 183)

Bion (1962b) introduced the term 'reverie' to describe the process whereby the receptive mother takes on board the infants often hostile projective identifications and through a gradual sifting of the feelings and thoughts she is experiencing, allows them to "evolve into an understanding of what the baby is experiencing" (Ivey, 2009: 117). This 'reverie' that the mother engages in is not merely a mirroring of the moods and impulses of the infant so that it can foster a sense of self in these reflections, it is an active engagement with the infant's mental state which shows the infant how its projections can be detoxified and metabolized - on other words, the mother shows how the chaotic impulses and sense impressions can be tolerated and "lent shape and form" (Waddell, 1998: 37). Further, it would be incorrect to say that what the mother is experiencing are the *actual* feelings of the infant - in health, she is flexible enough to allow the infants projections to impact *her* and she shows how such intense feelings can be tolerated and considered. The infant's projections which are of a sensory-somatic quality, Bion called them *beta-elements*, are transformed by the mother into something more mental (and appropriate for thought) in quality, Bion designated these *alpha-*

elements with the process coming to be known as the *alpha process* (or *alpha function*)(Britton, 1992).

It was only in his book, 'Learning from Experience', later that same year, that Bion (1962b) officially christened the place where the projection lands up the 'container' and that which is projected, the 'contained', but not without reservations, labelling both terms 'unsatisfactory' in nature. Bion (1963) saw the terms 'container' and 'contained' as impure representations of an unknowable central abstraction, and he believed that "words accrete to themselves a penumbra of images so in his text...substitutes the symbols ♀ and ♂ for container/contained" (Symington & Symington, 1996: 51). The use of these symbols also conveys the sense of a 'mating' taking place, a repetitive cycle of the coming together of pre-conceptions and realizations that "promotes growth in the ♀♂" (Bion, 1962b: 91) and, given the right environment, leads to thoughts evolving towards greater complexity and abstraction (Symington & Symington, 1996). As highlighted above, Bion (1962a) saw in the relationship between the mother and the infant the prototype of this ♀♂ model and believed that it instilled the mechanism for change and development in the infant. Waddell (1998) provides a helpful example when thinking about this early process that highlights the dynamic nature of the interaction between child and caregiver. She describes a situation where a young child is attempting to do a simple jigsaw puzzle, battling to figure out where a piece fits. She asserts that mothers in this situation might evince many different responses (or even the same mother could react differently at different times) but she singles out three responses that illustrate the vicissitudes of the ♀♂ relationship. In the first response the mother might see her child struggling and feel irritated that her child can not complete a seemingly simple puzzle and the child picks up on this, feels more anxious and less capable of completing it, and eventually starts crying or leaves the room. A second mother might pick up that her child is struggling with the puzzle and believe that the child's problem will be solved if she simply puts the piece into the correct place. The third mother might engage with the child, encouraging him or her to persevere a bit longer, giving hints if needed, getting a feel for the child's level of distress and turning the piece around the right way if needed, all of this in helping the child achieve a measure of autonomy through the exercise, a sense that they have the capability to complete the task. In the first example, the mother fails to contain the child's anxiety about not being able to complete the puzzle, it might not even be as focussed an anxiety as that, it may be an unthought about sense of worthlessness and badness that the child is projecting. The mother lacks the ability to sit with and transform these feelings of anxiety, with the result that they are returned to the child unmodified. In the case of the second mother, she has some capacity to tolerate the

child's anxiety and is able to act in a manner that she perceives as being helpful to the child. However, she doesn't have the capacity to sit with the feelings that the child has projected for long enough to be able to sift through them and work out what the child is truly trying to say. The child is not trying to communicate that it wants the puzzle to be solved, it is trying to tell the mother about the intense distress felt when faced with the prospect of having to do something without her. Repeated cycles of containment taking this form can lead to the internalisation of what Bion (1962a) describes as an object capable of tolerating enough frustration to avoid employing the mechanisms of evasion [i.e. excessive projective identification] but not enough to avoid developing a personality based on omniscience, an internal world that cannot survive without dictatorial moral strictures giving it coherence. The third example shows a mother who is sitting with the child's anxiety and sifting through the uncertainty for clues as to what the child is communicating, when she does intervene it is with an eye on how the child is responding, and in a way that allows the child to discover a sense of his own capacity and doesn't impose meaning on him.

The previous examples tend to portray the mechanism ♀♂ as essentially growth promoting and tend to lay the responsibility for the infants development of later pathology at the door of the mother or caregiver. But Bion had this to say in 'Elements of Psycho-analysis': "The benignity or otherwise of change effected by the mechanism ♀♂ depends on the nature of the dynamic link L, H, or K" (Bion, 1963: 33). L, H, and K stand for Loving, Hating, and Knowing respectively (Bion, 1962b) and are very much in keeping with Bion's emphasis on the dynamic *function* of the link between two objects – they can be seen as broad emotional mediums that colour the links between objects, and indeed, make these links possible (Cartwright, 2009). Bion saw in the dynamic interaction of the ♀♂ relationship the creation of a space where links could be forged, and he saw in this a representation of an "emotional realisation of a learning experience" (Waddell, 1998: 103) - after all, a pre-conception without a realization is an empty shell, devoid of meaning, the infants earliest conceptions are energised by an emotional experience of satisfaction or frustration (Bion, 1962a). L and H can be clearly seen to originate from the work of Freud and, even more so, Klein, but it was the K link that Bion privileged when considering these emotions – "the drive towards knowing, curiosity, the ability to think amidst strong affect, is a central part of the containing process" (Cartwright, 2009: 18). K stands for the ability to think about, and hence tolerate better, frustrations (1962b). This can be see clearly in the example of the third mother cited above, the desire to know and understand is part of the child's need to project its feeling – there is a desire to investigate this feeling in a personality strong enough to withstand its force (Bion, 1959). The third mother takes up

this challenge and sits with the feeling, sifting it for meaning, then engages with the child in a manner such that meaning evolves in the process of their interaction: K does not reside in the person of the mother, nor in the psyche of the infant, it is a product of their interaction and a process in which they can both grow emotionally. What the child then internalises is an object that can make meaning in the here-and-now of a variety of different interactions and thinking is not simply cast as an imposition of logic and rationality - it is a leap into the unknown and a capacity to endure the yawning void while waiting for meaning to take shape (Sandler, 2005). However, Bion (1959, 1962b), saw from early on that simply providing an environment conducive to this positive growth was not sufficient to avoid the development of later pathology - he remained faithful to Klein's notion of primitive envy and elaborated how an innate disposition could interfere with the process of containment. In 'Learning from Experience' Bion (1962b) returns to his oft quoted illustration of containment involving the infant projecting the fear that it is dying into the breast, showing that "K would moderate...the fear of dying...and the infant in due course would re-introject a new tolerable and consequently growth-stimulating part of its personality" (Bion, 1962b: 96). In his paper 'Attacks on Linking' Bion (1959) showed that an infant (of a highly aggressive innate disposition), when under the sway of primary aggression and envy, will produce attacks on that which links him to other objects – he goes on to assert that there is an interaction between the innate disposition and the environment in this situation, describing how the attacks can be diminished if the mother is able to contain the infants feelings. However, importantly, he asserts that the seriousness of the situation can never be abolished by environmental provision because the mother's ability to contain the intense feelings expelled without breaking down mobilises feelings of hatred and envy. Bion represented these attacks on links (and hence the container) as -L, -H, and -K and asserted that "in -K the breast is felt enviously to remove the good or valuable element in the fear of dying and force the worthless residue back into the infant. The infant who started with a fear he was dying ends up by containing a nameless dread" (Bion, 1962b: 96). At this extreme end of the spectrum, what the infant is left with is a breast that is felt to strip away meaning from the infants projections and what is internalised is an internal object that "starves its host of all understanding that is made available" (Bion, 1962a: 182).

What this chapter has attempted to portray is the complexity of the interplay between infant and mother when viewed through the prism of Bion's concept of the container/contained. The notion that projective identification could be both communicative and destructive is central to his understanding of the interaction between the mother and the infant. Together with his concept of

maternal reverie this had profound implications for how the analyst could apprehend countertransference phenomena in the clinical setting. This is something that we will turn our attention to in Chapter 4 but before we do that, let's have a look at Winnicott's developmental theory and model of mind.

Chapter 3 - Winnicott's Developmental Theory and Model of Mind

This chapter takes as its focus the developmental aspects of Winnicott's theory with specific emphasis on the processes involved in the holding phase and the infant's move from absolute dependence towards relative dependence. Winnicott's work charts a course through the dialectics of the Freudian and Kleinian positions and the 'Controversial Discussions' to arrive at an idiosyncratic theoretical matrix which foregrounds his preoccupation with the bond between infant and mother (Abram, 2008). The focus of much of Winnicott's work can probably be best expressed by the quote below from one of his later works:

> [A] baby can be said to live in a conceptual or subjective world. The change from the primary state to one in which objective perception is possible is not only a matter of inherent or inherited growth process; it needs in addition an environmental minimum. It belongs to the whole vast theme of the individual travelling from dependence to independence
>
> (Winnicott, 1971: 151)

While Winnicott seemingly foregrounds innate factors in this quote, and in doing so situates himself in the context of the ground covered previously by Freud and Klein, it is his use of the word 'minimum' when describing environmental provision that highlights the focus of his work. For Winnicott, the provision of a facilitating environment was non-negotiable if the infant was expected to stay on the path of healthy development. Indeed, Winnicott believed that there was no such thing as an infant and that without the mother's care the infant would die, further asserting that "at the earliest stages the infant and maternal care belong to each other and cannot be disentangled" (Winnicott, 1960: 40). For Winnicott, the inherited potential of the infant was something that could unfold at a later date and that the presence of the "good-enough mother" in those very early stages "provides a setting for the infant's constitution to begin to make itself evident, for the developmental tendencies to start to unfold" (Winnicott, 1956: 303). He is even more emphatic in a later paper when he states that he will countenance the idea of an inherited potential "provided that it is accepted that the inherited potential of an infant cannot become an infant unless linked to maternal care" (Winnicott, 1960: 43).

In his early paper, 'Primitive Emotional Development', Winnicott (1945) laid the groundwork for most of his later psychoanalytic developments by describing the early developmental processes as he saw them (Ogden, 2001). His concept of holding, which had developed through his work with evacuee children during World War II (Abram, 2007), found explication in this paper and in his tentative exploration of all that this deceptively simple concept suggested he foreshadowed his psychoanalytic innovations of the next two decades. The focus of this paper is on the earliest stages of infancy, locating his focus in the stage "before the infant knows himself (and therefore others) as the whole person that he is (and that they are)" (Winnicott, 1945: 149). Winnicott (1945) believed that the infant was engaged with three processes during these very early stages, namely integration, personalization, and realization, with the process of integration receiving the fullest explication in this paper. Winnicott (1945) posited a notion of primary unintegration in the neonate, describing how integration is a process that begins at the advent of life but that it is not a given - he gives it a more fluid character, as opposed to delineating it as a set of developmental milestones that once traversed, are left behind. Winnicott further asserts that this state of early primary unintegration supplies the basis for later disintegration (in the psychopathological sense of the word) and the infant who suffers setbacks in the process of primary integration will be more prone to this type of disintegration in later life. Winnicott believed that the process of integration was aided by two types of experience, firstly "the technique of infant care whereby an infant is kept warm, handled and bathed and rocked and named, and also the acute instinctual experiences which tend to gather the personality together from within" (Winnicott, 1945: 150). At first glance, this statement doesn't seem too controversial - a developmental theory that takes in both innate factors and environmental provision. However, as will be discussed at a later stage, Winnicott's views on the nature of instincts and how they play out are distinct and unique.

A cornerstone of Winnicott's (1963) concept of holding was the notion that at the beginning of life, because an infant is in a state of primary unintegration, it is also in a state of absolute dependence on the mother. For Winnicott, the word 'holding' didn't merely denote the mother's "actual physical holding of the infant, but also the total environmental provision" (Winnicott, 1960: 43) and what the good-enough mother essentially does in the holding process is provide an as near-perfect adaptation to the infant's needs as is possible in order to foster a continuity of being in its world that aids in the process of integration. In a prescient elucidation of the holding process Ogden (2004) sees, in the mother's adaptation to her infants needs, her "insulating the infant in his state of going on being from the relentless and unalterable otherness of time" (Ogden, 2004: 1350). What Ogden is saying is

that the mother's adaptation has to protect the infant from the impingements of reality and through providing an illusion that the world functions almost solely on the exigencies of the infants needs, helps the maturational processes to foster a sense of integration in the infant. Winnicott (1960) set up two alternatives for how the infant could exist in this early crucial time: being (continuity of) or annihilation. If the mother, for whatever reason, fails to identify with her infant sufficiently during the time of primary maternal preoccupation and provide the necessary adaptation then the infant expends its energy reacting to impingements and therefore the "holding environment...has as its main function the reduction to a minimum of impingements to which the infant must react with resultant annihilation of personal being" (Winnicott, 1960: 47). In the very beginning, when the dependence of the infant is absolute, Winnicott (1949) believes that holding provides an environment that is essentially a physical one, be that in the womb or just having its needs tended to. In his landmark paper 'Mind and its relation to the Psyche-Soma', Winnicott (1949) comes close to laying out a theory of mind, something that he seldom does in his work - tending to focus on more descriptive, plain language elucidations over more metapsychological constructions (Fulgencio, 2007). Winnicott used the term psyche-soma to describe the individual's general body scheme and saw the mind as part of the functioning of this psyche-soma (i.e. not separate), and he believed that the mind could not come into being as an entity or function in this scheme if the psyche-soma has not satisfactorily come through the developmental stage falling under the heading: holding. This is linked to Winnicott's (1945) earlier notion of 'personalization' which he defined as the "development of the feeling that one's person is in one's body" (Winnicott, 1945: 150). In an (almost throwaway) line early on in this paper, Winnicott has this to say: "I suppose the word psyche here means the *imaginative elaboration of somatic parts, feelings, and functions*, that is, of physical aliveness" (Winnicott, 1949: 244, italics in original). This represents a radical re-conception of Freudian (and Kleinian) understandings of bodily excitations and their psychic corollaries and, for Winnicott, it is no longer "a question of interplay of forces between the representations or affects, but a psychosomatic existence that is lived out and bestowed with meaning in inter-human relationships, be it from the viewpoint of the self or that of the individuals relationship to the environment" (Fulgencio, 2007: 450). What this means is that the development of a mind is one not governed by innate factors but very much influenced by environmental provision. So, in this we can see that Winnicott is relocating the arena of psychic life from the internal world of the individual (which was a strong focus of the Kleinian contribution at that time) into the environment.

Winnicott (1963) believed that, in health, the developmental trajectory of the infant involved beginning in a state of absolute dependence, and from there progressing to a state of relative dependence and then a later state which he called “towards independence”, with the facilitating environment providing the arena for the maturational processes to drive this trajectory. In this state of absolute dependence the infant is merged with the mother, and the mother with the infant in a state of primary maternal preoccupation, and it is through the process of holding that the infant “changes from a relationship to a subjectively conceived object to an object objectively perceived” (Winnicott, 1960: 45). While Winnicott does assert that this separation out of mother and infant belongs more fully to the phase of ‘living with’ which succeeds the holding phase, he leaves it open as to when the separation begins and is at pains to point out that there is substantive overlap between the phases of holding and living with. In his later writing Winnicott (1971) sets out a distinction between object relating and object usage with the former describing relationships with a subjectively conceived object and the latter with an objectively perceived object. What Winnicott means by this, is that the infant becomes progressively more aware of the object’s independent existence - the object’s survival of the infant’s destructive attacks show the infant the limits of its power and fosters a greater recognition, in the infant, of what is inside and what is outside. Crucially, Winnicott believes that this capacity to use objects is a capacity that develops through the holding phase and into the living with phase - failure in maternal provision in these phases can lead to the infant not adequately recognising the object as an external phenomenon with the result being severe later psychopathology.

The question of how this separating out of mother and infant takes place (and what foundations need to be laid during the early stages) is one that Winnicott provides no easy answers for. He considers it from many different angles and comes up with a multitude of different processes operating simultaneously, which can be quite difficult to assimilate into one coherent overarching developmental trajectory. One gets a sense that in his emphasis on the environment, Winnicott would prefer to leave the role of instincts and their vicissitudes unexamined - the sense is that for him answers could be found in the environment and debating this or that amount of death or life instinct seemed a pointless endeavour (Fulgencio, 2007). His papers are littered with the uses of the terms ‘maturational processes’ and ‘inherited potential’ which seem to be an attempt to move the debate away from the connotations and polarity of ‘life’ and ‘death’ or ‘love’ and ‘hate’. However, Winnicott (1950) does attempt to map out his views on the role played by instincts and their affects in his paper on aggression. In distinction to Klein, for Winnicott there is no asking whether the infant

has a strong or weak ego at the start of life because the answer lies in the mother's ability to cope with the infant's absolute dependence, her ego is used by the infant as an auxiliary, and indeed, is regarded by the infant as its own (Winnicott, 1962). For Winnicott, the term ego is used to delineate that "part of the human personality that tends, under suitable conditions, to become integrated into a unit" (Winnicott, 1962: 56). Early on in his paper on aggression, Winnicott (1950) asks the question whether aggression can be said to be the product of frustration or whether it has its own innate root, and this lies at the heart of his endeavour in this paper: to tease out what of the inherited potential and in the adaptive environment is responsible for the early integration and then individuating of the infant. In the excitement of the primitive love impulse (or id) Winnicott believes that one can always "detect reactive aggression, since in practice there is no such thing as a complete id satisfaction" (Winnicott, 1950: 210), and although this impulse may be destructive by chance the infant has not attained ego integration and so cannot be held responsible for his actions [i.e. what Winnicott is saying is that the infant is not doing it on *purpose* a la Klein's infant launching envious attacks].

But Winnicott delves further into this aggressive element in order to find what may lie at the heart of the unintended consequences of the primitive love impulse and links it to the concept of motility, a biological term that suggests primitive non-purposive movement, which is present from intra-uterine life (the baby kicking in the womb, for example). Winnicott (1950) asserts that the infant needs to expend as much of this primitive motility as possible into the id experiences as these help to gather together and integrate the experiences of the individual. So, particularly in the earliest experiences of the infant, the motility which is fused with the erotic potential in the service of instinctual gratification helps to foster a continuity of going-on-being. However, for Winnicott (1950), no id experience can ever be 100% satisfying because of the limitations of reality and so there is some left over motility which needs to be used lest it remain unexperienced and a potential threat to well being. This unfused motility potential is used in reaction to frustration and, depending on the amount of frustration available in the environment, is for Winnicott the underlying basis for the variety of levels of aggression in people. However, the aggression in reaction to frustration needs opposition and in the environment provided by the good-enough mother the amount of aggression generated aids in the infant's establishment of *Me* and *Not-Me*. The erotic impulses can be satisfied while the "object is subjectively conceived or personally created" (Winnicott, 1950: 215) but the aggressive impulses are felt to be unsatisfactory if there isn't opposition. So, through the exercise of its aggressive impulses, the infant is able to discover more fully the shape and form of the

environment it finds itself in. When there are significant failings in environmental provision then the infant has to use up a lot of its motility reacting to impingements, and instead of using this motility in the ongoing process of delineating the borders between itself and the reality of the outside world, the reacting infant only encounters reality and feels real whilst reacting. At the end of the reading, Winnicott (1950) asserts that what is seen as aggression is merely an impulsive gesture, seen as so when it encounters opposition. In this lies a hint of what he developed more fully later in his paper, 'The Use of an Object and Relating through Identifications' (1971), that it is in the infant's destructiveness and the objects survival that a more realistic objectively perceived object is created.

Winnicott constantly emphasises the role of the mother in the early stages and he repeats over and over throughout his writing his belief the "good-enough mother...starts off with an almost complete adaptation to her infant's needs" (Winnicott, 1971: 10), and he repeats it because none of the later developments (especially the separating out of mother and infant) can come about without this phase being adequately traversed. In the beginning, the mothers provision of almost total adaptation provides the infant with the opportunity to have the illusion that the breast is part of the infant and is magically controlled by the infant (Winnicott, 1962). As an aside and in strong contrast to the ideas of Bion (and one that will be elaborated upon in later chapters), Winnicott (1962) posits that there is no interchange between the mother and the infant in this early process and that the "infant perceives the breast only in so far as the breast could be created just there and then" and that "psychologically the infant takes from a breast that is part of the infant, and the mother gives milk to an infant that is part of herself" (Winnicott, 1971: 12). It is these brief experiences of omnipotence that lay the foundations so that the "baby can [begin to] meet the reality principle here and there, now and then, but not everywhere all at once" (Winnicott, 1962: 57). In other words, the highly attuned adaptation of the mother in these early stages provides the infant with enough continuity of going-on-being so that the disparate parts can begin to integrate so that unthinkable anxiety can be avoided. Winnicott (1962) characterises infants in these early stages as always on the brink of unthinkable anxiety, sometimes further away and sometimes closer to the precipice, but always near to anxiety about going to pieces, falling for ever, and having no relationship to the body. Winnicott (1971) doesn't confine the provision of going-on-being and the brief experiences of omnipotence to the breast and the basics of maternal care, he hypothesises that this continuity can (and should) be facilitated in the mother's face and her expressions. In the early stages, what the infant sees when it looks into its mothers face "is himself or herself. In other words the mother is looking at the baby and *what she looks like is related to what she sees there*"

(Winnicott, 1971: 112 - italics in original). If what the infant sees when it looks into its mothers face is only her moods or defences then he can lose track of the continuity of his being and has missed out on a badly needed experience of omnipotence. The repeated loss of this experience can lead to the atrophy of the infant's creative capacity - the failure of the infant's creative gesture to find purchase on the mothers face will lead to a stifling of its ability to perceive and of its ability to tolerate the quiet moments of unintegration during the holding phase. We have spoken at length about the mother's needs to provide near-perfect adaptation in the very early stages of the holding phase (Winnicott is vague on how long this stage actually lasts, one gets the sense that he means a few weeks), and Winnicott goes on to assert that while "the infant does need perfect adaptation at the theoretical start, [it] then needs a carefully graduated failure of adaptation" (Winnicott, 1950: 216). In Winnicott's terms, following our discussion of aggression above, we can certainly see the value of this graduated failure; the frustration produced energising the infant's efforts to distinguish between *Me* and *Not*-Me. But the question arises as to how this graduated de-adaptation takes place, how does the mother sense that she should pull back slightly from her near-perfect adaptation, at what point does she know that the infant is ready for this process to begin? Winnicott is enigmatic on this point, labelling it as part of the 'equipment' of many mothers to be able to provide this graduated de-adaptation and that sooner or later "the mother will grow up out of this state of easy devotion" (Winnicott, 1963: 88) and begin to realise that she has a life separate from the infant. Taking a step back and examining how Winnicott (1949) feels a mother is able to achieve this state of primary maternal preoccupation might enliven our understanding of how she is able to move out of it - he asserts that it is through her memories, her narcissism, and her imagination that she is able to attain the appropriate level of identification with her baby's needs. In a later paper, he goes on to assert that mothers "identify themselves with the baby that is growing within them, and in this way they achieve a very powerful sense of what the baby needs. This is a projective identification" (Winnicott, 1960: 53). Put in these terms, one can see how a mother becomes identified with her infant and how this projection can wear off as time moves forward after parturition, thus facilitating the mother's gradual de-adaptation.

It is worthwhile to consider the consequences of failures in the holding environment during these early stages (and the associated defences) in order to provide reference points for our later comparison of holding and containment. We have already considered Winnicott's (1962) notion that the neonate is always on the brink of unthinkable anxiety, but he also includes the development of schizophrenia and of a schizoid personality as consequences of severe disruptions in environmental

provision during the early phase. The opposite of integration for Winnicott is the previously mentioned unintegration, the provision of a nearly unbroken line of continuity of being providing the infant with the resources to navigate these periods of unintegration. One of the defences that Winnicott (1962) posited against fragmentation in the line of continuity of being was disintegration which involves "an active production of chaos in defence against unintegration...[and] may be as 'bad' as the unreliability of the environment, but it has the advantage of being produced by the baby and...within the area of the baby's omnipotence" (Winnicott, 1962: 61). What this means is that even though the consequences of disintegration are disturbing for the infant, the fact of feeling that it is under his or her control provides some measure of coherence to its internal world. One of the most important concepts to emerge from Winnicott's (1960) examination of the consequences of the failures in environmental provision was the notion of the True and False Self. At the heart of the True Self lies Winnicott's favoured idea of the spontaneous impulse (or creative gesture, as described above), with this gesture originating from this True Self - the True Self can be thought of as the developing ego although he doesn't completely align the two concepts. The function of the False Self is, at its most basic, to defend and protect the True Self against annihilation. Winnicott (1960b) sets up the varieties of the False Self up on a spectrum with one extreme (ill-health) characterised by a False Self masquerading as the True Self, with this coming undone in interpersonal situations where a whole person is required. In the movement more towards health the False Self is tasked with protecting the True Self and finding conditions in which it can flourish. At the other extreme (health) the False Self is never completely discarded and is represented by our "polite and mannered social attitude" (Winnicott, 1960b: 143) which provides space for the True Self to exist without too much of a compromise of its integrity. The concept of the True and False Self provides Winnicott with a means of characterising many forms of psychopathology and with a tool with which to trace back the problems of those presenting for analysis to a point where the fault occurred - obviously not with perfect clarity but it enables the analyst/therapist to get a sense of when, where, and what the failures in environmental provision may have been and felt like.

The emphasis of this chapter has been on holding and its place within the developmental theory of Donald Winnicott. In the next chapter we look at how, in the clinical milieu, the 'good-enough mother' is translated into the 'good-enough therapist'. Through the use of a lengthy clinical vignette we examine what, if anything, is lost in this translation of how the notion of 'primary maternal preoccupation' can be adapted and applied by a therapist in the clinical setting.

Chapter 4 - Comparison of Holding and Containment

In the previous chapter we saw how differently Winnicott apprehends the early stages of the infant's life in comparison to Bion. The early focus of this chapter will be to compare and contrast the the developmental theories of them both, the previous two chapters laid out the respective developmental theories but now we will spend some time teasing out the essential differences in these models of mind. Once we have done this we will then compare holding and containing in the clinical setting and illustrate this with case material from Masud Khan (1960) and John Steiner (2000). Winnicott's most strongly expressed disagreement with Melanie Klein was, perhaps unsurprisingly given the constant emphasis it finds in his work, her treatment of environmental factors. He found himself increasingly at odds with Klein's (1946, 1957) intense focus on the vicissitudes of the infant's instinctual life and her emphasis of the role that it plays in the early milieu, going so far as to describe her as "temperamentally incapable" of paying anything more than "lip service" (Winnicott, 1962: 177) to the environmental factor. In the same paper, he lists her more doubtful contributions to psychoanalysis as her retention (and development) of the Freudian notion of the life and death instincts, and her formulation of the infants aggression and destructiveness in terms of inherited factors and primitive envy. Indeed, as was demonstrated in the previous chapter, Winnicott (1950) saw infantile destructiveness in the very early stages of life as being part of the unintended consequences of the primitive love impulse and was merely destructive by chance. Some authors (e.g. Isaacs-Elmhirst, 1980) have argued that Bion's development of the container/contained represents a middle path through the dichotomy set up by Winnicott and Klein's respective positions. Isaacs-Elmhirst (1980) asserts, however, that this lack of interest in the environment is rather a corner that Winnicott and others have painted Klein into. In her paper 'On observing the behaviour of young infants', Klein (1952) stresses the importance of the environment all through the early stages of a child's life, which would seem to contradict Winnicott's portrayal of her position. However, in the same breath, she goes on to say that while the environment is important, psychopathology can come out of favourable surroundings and healthy development out of a trying environment. Perhaps it is Winnicott's intense pre-occupation with the early environmental provision that led him to see Klein as so temperamentally incapable of recognising it for herself. At any rate, Bion's (1962a) foregrounding of the interaction between the mother and infant as a developmental imperative (and this from someone closer to the Kleinian fold) can be seen as a significant development of Kleinian theory, some would say beyond recognition (Ferro, 2005), that takes heed of the environment.

However, as will have become apparent from the preceding chapters outlining Bion and Winnicott's respective models of mind and developmental theory, while they may both have given attention to the environment, there are vast and substantive differences between their two viewpoints. From very early on in her writings, Klein (1932) had asserted that the infant had an ego from birth and from this beginning used projective and introjective mechanisms to protect against early anxiety. Inherent in the lengthy quotation of Klein's (1946) given early in Chapter 2 is this notion of an infantile ego from birth and also the idea that excessive use of projective identification serves to blur the early distinction between self and object. Bion (1957, 1959, 1962a) picked up on both of these ideas and showed how projective identification could be used to build upon this inchoate sense of self and object. But also, when used excessively, could be used to attack that which links self and object in order to defend against the psychic pain felt in the awareness of reality. As we have seen from our discussion of Winnicott in the previous chapter, he didn't believe that there was an infantile ego from the start of life; rather the infant has no realization of the separateness of self and object in the stage of absolute dependence. Indeed, he felt that the "*start* [of this awareness of separateness] is when the ego starts" (Winnicott, 1962: 56 - my emphasis). However, to complicate matters, Winnicott goes on to assert that "the ego offers itself for study long before the word self has relevance" (Winnicott, 1962: 56). What he means here is that simply because the infant is beginning to integrate parts of its personality during the holding process, it doesn't mean that it has a firm sense of difference between 'Me' and 'Not-Me'. But this then raises the question of what actually does start at this *start* (of the ego)? If we accept that the infant in Bion's conception is busy from birth using cycles of projective and introjective mechanisms to strengthen the link to the object and thus provide succour to the developing ego (while, in ill-health, doing the opposite), then what activity is the Winnicottian infant engaged in at this very early stage? He felt that there was little use hypothesising about the activities of infants in this early stage without reference to the mother with which it forms a unit, as the infant is close to the state of primary unintegration and absolutely dependent. Winnicott (1950) conceded that there were times when the infant looked to be engaged in aggressive and destructive behaviour, but that this was co-incident to the primitive love impulse and that the infant could bear no responsibility for it. This represents a very clear difference to the work of Bion - from the first, Bion's infant is aware of the object and can use primitive mechanisms positively or negatively in its interaction with it; Winnicott's infant is unaware of the separate existence of the object, and on an integrative path under the aegis of the good-enough mother.

This leads us onto a consideration of the differences and similarities between Bion and Winnicott's conception of the role of the mother in these early stages. On the one hand we have the mother who engages in "reverie" in her interaction with her infant, and on the other we have the "good-enough mother" in a state of "primary maternal preoccupation". For Winnicott (1962a), the good-enough mother plays an inherently positive role in the development of the infant with her presence fostering the continuity of going-on-being that allows the infant to move towards a stage of greater integration. As we have seen in our discussion in the previous chapter this early preoccupation of the good-enough mother is a state of heightened sensitivity to the needs of the infant, which Winnicott (1956) sees as akin to an illness, characterised by "delicate adaptation" to the infants needs. As mentioned previously, Winnicott is slightly vague on how the mother achieves this state - he believed that there were biological reasons but he felt that its occurrence needed a more detailed psychological understanding. Winnicott's (1949, 1956, 1960, 1971) understanding of what was happening in the mother seems to have evolved over time and is not entirely cohesive. As we saw in the last chapter, in an earlier paper he asserted that the good-enough mother uses her memories, her narcissism, and her imagination to attain the appropriate level of identity with her infants needs. Winnicott (1960) then goes on in a later paper to class this identification as projective identification. Winnicott's (1971) views on projective identification are to a certain point, in line with the general Kleinian view, in that he believed that it involved projection *into* the object. However, he saw it as a sophisticated development in the infant, one only reached once a fairly clear separation of 'Me' and 'Not-Me' has been achieved and, hence, not operative in the infant during the holding stage. Winnicott confuses the matter slightly in a later paper where, while describing breastfeeding in the holding stage, he asserts that there is "no interchange between the mother and the infant...the mother gives milk to an infant that is part of herself...[and] the idea of interchange is based on an illusion in the psychologist" (Winnicott, 1971: 12). This part of his theory is difficult to reconcile - if the mother is merged with the infant (in a kind of "illness" for her) then she would lack the developmental sophistication to be employing the projective identification to gauge her infants needs; and further, if the mother *is* using projective identification then presumably this involves some form of interchange with the infant (in one direction, at least). It would be tempting to see this as another Winnicottian paradox, but the contradiction seems more real than apparent.

Given Winnicott's views on the developmental sophistication of projective identification it would be of interest to hear what his views on Bion's theory of the container/contained were. He never appears to address himself to the concept directly but in a later work he describes how it is only in

the sense of existing ("BEING" as he puts it) facilitated by the holding stage that one has the "capacity to develop an inside, to be a container, to have a capacity to use the mechanisms of projection and introjection and to relate to the world in [these] terms" (Winnicott, 1971: 82). So, in my opinion, Winnicott is saying here that he can countenance the idea of the container and the inherent projective mechanisms but that there has to be a period of holding guiding the infant towards independence before it is able to engage in these processes. This is not how Bion (1962a) saw the process of containment unfolding - he clearly believed that the infant was able to be conscious of its "sense-data" from the beginning and while it may not at this outset have the ability to make much use of this data, it has the wherewithal to use projective identification so that it can "investigate [its] own feelings in a personality strong enough to contain them" (Bion, 1959: 98). For him, it is in the "interplay through projective identification between the rudimentary consciousness and maternal reverie" (Bion, 1962a: 183) that the infants development plays out. One might be tempted to ask at this point: Is this really that different to holding? Over and above the tensions in Winnicott's theory, surely their versions of the mother are engaged in more or less the same process?

But they are different, and for two crucial reasons. Firstly, the Winnicottian mother is involved in an *imaginative* exercise where she is using her own experience and memories to guide her adaptation to the infant, at no point does Winnicott indicate that she is responding to communication from the infant. This is in stark contrast to Bion, who saw in the mother's reverie "the capacity...to receive and respond creatively to the baby's projected...chaos and confusion" (Isaacs-Elmhirst, 1980: 87). In other words, her ability to respond to projective identifications which Bion (2005) saw, in the normative scenario, as *communication*. In fact, for Winnicott (1963) there was a personal core self at the centre of which "*each individual is an isolate, permanently non-communicating, permanently unknown, in fact unfound*" (Winnicott, 1963: 187, italics in original). What he means by this is that for the healthy development of communication in later life, there is a non-communicating central self (the True Self) in the infant that must have its experience of impingements limited during the holding stage, as it is from here that its sense of 'aliveness' and feeling 'real' originates from.

The second crucial difference lies with the inchoate infantile ego and the rudimentary consciousness it bestows - in Bion's conception of the early stages this gives the infant the agency to manifest (primarily through the vehicle of projective identification) its innate disposition. As discussed in

chapter 2, Bion (1959) believed that even the most ideal and nuanced environmental provision could not prevent later psychopathology if the infant possessed a highly aggressive innate disposition, it could ameliorate some of the disturbance but not abolish it. The point in this is that, in contrast to holding, the interaction of container and contained is not necessarily positive and growth promoting - the interaction is capable of hindering or enhancing development and Bion outlined a number of pathological container-contained variants. Bion (1962b) described the link between container and contained that was beneficial and growth promoting to both the mother and the infant as "commensal". In a later work he went on to flesh this out by describing the types of links further as "symbiotic" and "parasitic" and says: "By 'symbiotic' I understand a relationship in which one depends on another to mutual advantage. By 'parasitic' I mean to represent a relationship in which one depends on another to produce a third, which is destructive to all three" (Bion, 1970: 95). In this we can see that Bion remained implicitly faithful to the Kleinian development of the life and death instincts originally proposed by Freud (1920) and, as shown in chapter 2, he described the ways in which they could affect the interaction of the container and contained. Winnicott (1963, 1965) objected to the concept of the death instinct instead, as mentioned above, seeing destruction as a by-product of the primitive love impulse and aggression in later life a result of failures and frustrations in early environmental provision.

Clinical illustrations of holding and container-contained phenomena

We now turn our attention to clinical practice in order to investigate how the concepts of holding and containment inform and contextualise therapeutic action. To this end, through the use of case vignettes the paper will describe how Bion and Winnicott approached clinical practice, drawing out the differences and similarities between them. In his paper on the 'Metapsychological and Clinical Aspects of Regression within the Psychoanalytical Set-up', Winnicott (1954a) describes how he classifies cases according to what they require of the analyst. He delineates three categories: the first he sees as whole persons whose problems are of an interpersonal nature and for whom classical treatment, along the lines of that described by Freud will suffice. The second group he casts as requiring an analysis of the depressive position (his 'stage of concern') entailing the coming together of love and hate, requiring similar technique from the analyst as the group above except with a focus on the survival of the analyst. He saw this group as having achieved wholeness but having a tentative grip on it and the dependence implied, and the environmental failure it corresponds to is the mother's not "[holding] a situation in time" (Winnicott, 1954a: 279). The third group that he refers

to are those for whom there has been a significant disturbance in their primitive emotional development and for whom the personality is not properly achieved "space-time unit status" (Winnicott, 1954a: 279) through good-enough mothering. It is this last group that receives the most attention amongst Winnicott's clinical material and for whom he believed that regression to dependence was what was required of the analysis. The third group appears to represent most clearly the failures of maternal holding, and the case material presented below describes such a regression and will attempt to illuminate the principles of analytic holding.

Before moving onto this case material it is worth touching upon Winnicott's views on interpretation and countertransference. It is safe to say that as his career progressed, Winnicott became increasingly wary of interpretation in psychoanalysis. He often described it as a demonstration of the analysts 'cleverness' and felt that it was most helpful to the patient when the traumata can enter the "psycho-analytic material in the patient's own way, and within the patient omnipotence" (Winnicott, 1960: 37). This is linked to the 'brief experience of omnipotence' discussed in Chapter 3 where the illusion provided by the good-enough mother's adaptation bolsters integration in the infant (Winnicott, 1971). He felt that interpretation was most effective when the patient has the capacity "*to place the analyst outside the area of subjective phenomena*" (Winnicott, 1971: 87), which he believed the patients in the third group are unable to do (hence the need for a regression to dependence and limited interpretation with them). Although not fully regressed to dependence, the patient cited by Winnicott (1954b) in his paper 'Withdrawal and Regression' provides a good example of his approach to interpretation. At one point during the analysis, this schizoid-depressive patient relays to Winnicott that he feels like he is curled up in a ball (even though he was not) who replies by interpreting the patient's need to be held in space and time, and the "emphasis [is] on the interpretation conveying a sense of the holding function of the therapist rather than on giving understanding" (Spurling, 2008: 527). When thinking about countertransference, Winnicott (1960c) believed that the majority of patients required the classical psychoanalytic technique, one where countertransference refers to the "neurotic features *which spoil the professional attitude* and disturb the course of the analytic process as determined by the patient" (Winnicott, 1960c: 162). The exception that he made to this traditional Freudian view of countertransference was with psychotic and borderline psychotic patients, whom he believed regress to a state of such extreme dependence that they will inevitably break through the analysts barriers and forge a "direct relationship of a primitive kind, even to the extent of merging" (Winnicott, 1960c: 164). In his paper 'Hate in the Countertransference', Winnicott (1947) asserts that an analyst will not readily be able to tolerate

working with such patients unless he can perceive the objective hate engendered by them (and presumably tell it apart from his own primitive feelings). Winnicott likens this to the hate that the mother bears for the infant because of all the demands that it places on her.

Winnicott believed that for a regression to take place in the analytic setting there must have been a "failure of adaptation on the part of the environment that results in the development of a false self" (Winnicott, 1954a: 281), and that the analytic setting (and person of the analyst) provided the space in which such a regression could take place. This represents the ill-health part of the spectrum of possible manifestations of the False Self that Winnicott (1960b) posited, as we saw in Chapter 3 some manifestations of the False Self are adaptive and serve the purpose of social integration. It was his belief that the infant's defence against environmental deficiency involved a "freezing of the failure situation" in the (largely unconscious) hope that opportunity will present itself at a later date where it can be unfrozen "with the individual in a regressed state, in an environment that is making adequate adaptation" (Winnicott 1954a: 281). He also believed that the therapeutic setting in regression involved two people (as opposed to three people with one absent which represents the more Freudian Oedipal dynamic) and the "setting represents the mother with her technique, and the patient is an infant" (Winnicott 1954a: 286).

The more lengthy vignette chosen to illustrate holding in the analytic setting comes from the work of Masud Khan (1960) and, in his own words, describes how "the regressive and integrative processes crystallized in the analytic setting" (Khan, 1960: 138). His patient, Mrs X, a woman in her early forties, had been referred to him after she had suffered a breakdown. Her and her husband (who had just recovered from a psychiatric hospitalization), and her eight year old son were due to move to another town and she had experienced, by the sound of things, a dissociative break and had been found wandering around her neighbourhood in confusion and panic. Her husband (with whom she had a strained and tumultuous relationship) and her son moved to the other town and it was agreed that after two years analysis that she would go and join them. The analysis went on for a period of three years after which Khan felt that she had made a good recovery from her illness. Khan (1960) divided the analysis up into the three phases with each phase characterised by differences in her way of relating to him and to the outside world. In the beginning of the first phase Khan is impressed with her determination and optimism surrounding her treatment but also notes a definite substrate of depression and apathy. He notes that for the first seven months her treatment "ran a very

smooth and classical course" (Khan, 1960: 144), where he was able to put her in touch with some of her ambivalence, interpret some of her aggression towards her son, and her defence mechanisms. This description of a classical course reminds one of some of Winnicott's (1949, 1960) vignettes where he speaks about patients who have turned up for an analysis with him and have had previous analyses before that were judged successful but there is still this intractable disturbance in their life. He attributes this to analysts doing analysis of these patients False Selves, quite sophisticated False Selves that can engage with the traditional analytic process while leaving the central disturbance unaltered. Mrs X's enthusiasm for the treatment, over and above her depression, can be seen as a sign of this False Self.

Khan (1960) then charts how after nine months of more classical analysis she starts to become withdrawn, restless, and irritable in the sessions and in her social environment (she works at a school). This then escalates into euphoric and elated omnipotence, attempting to take charge of the analysis and triumphing over the interpretations and experiences of the first months of treatment. Khan (1960) felt that one of the functions of her mental state was that it "obviated her dependence on her environment and on [himself, and that] it was the opposite of regression in analysis" (Khan, 1960: 147). Khan refrains from interpreting the vast amounts of content emerging during this stage too much, preferring to keep steadfast and hold her through the mania. In the run up to the first major break in the treatment (her husband sponsors an overseas trip for her) the manic stage culminates in her shoplifting two books, gigglingly presenting them to Khan during a session. He doesn't react and quietly offers to return them if she so desired. She agrees and the next day comes to the session saying that she had had a dream the night before but had forgotten it when she woke up but that she had thought then that she would have killed herself if she had been caught stealing. Khan eschewed making substantial interpretations all through this event, as Winnicott (1960) would recommend, and sees her comments above as evidence that he was right not to have "bullied and humiliated her with interpretations" (Khan, 1960: 148). Instead, he has held the situation and allowed the chaos and aggression of her actions to find some measure of integration in the person of the analyst and in the setting (Winnicott, 1945). The effect of this is to sober Mrs X somewhat and she recalls some of her aggression towards her son and vividly recalls how it felt during times when in her life when she was suicidal.

For Khan (1960), the second phase lasted for eighteen months and it was during this time that Mrs X regressed to dependence and he sees it as beginning on her return from the break. On her return from the break Khan (1960: 149) finds her in a state of "depressively toned relaxation" and finds it quite easy to work through the stealing episode in the transference, linking it to deprivations in childhood and identifications with her mother. He quotes Winnicott's (1956) 'The Antisocial Tendency' at length in his consideration of the incident and sees Mrs X's theft as a seeking out of the "*mother over whom…she has rights*" (Winnicott, 1956: 311), and that it is a positive sign as the hopeful patient is seeking out an environment which can remedy the deprivations encountered during the holding phase. This reinforces the point made above about how Winnicott (1956) viewed it as imperative that the environment (the analytic setting) hold in this case, that it is able to withstand the patient's aggression when tested in this way. The consistency of the holding environment provided by Khan facilitated her moving into a period of intense grief and sadness that he saw as part of the gradual movement towards regression to dependence. The event that triggers her entrance into the regression proper, which he feels lasted for three months, is her husband being dismissive of her by not answering her letters. The first session of it she is in such psychic pain that Khan (1960) believes that he can feel it in himself and he can feel how her strength has ebbed away. He staves off interpretation, saving it for the end of the session where he tells her he knows how much pain and frustration she is experiencing and that this is why she has sought treatment. This links with Winnicott's (1954b) interpretation in 'Withdrawal and Regression' - interpretations that describe the analyst's capacity to hold and interpretations that speak to that part of the patient that sought out such a remedying environment (i.e. the True Self).

Her state during the regression is characterised by Khan as being one of overwhelming grief and psychic pain, and near-absolute dependence on him (and some of those in her environment). He sees his role at this stage to be "*there*, alive, alert, embodied, and vital, but not to impinge with any personal need to translate her affective experiences into their mental correlates" (Khan, 1960: 157). We can see in this Winnicott's (1963) injunction that at times of deep regression such as Mrs X was in, there is a personal core self (the True Self) that should remain inviolate, and having to communicate (by responding to an interpretation, for example) would be an impingement. That is not to say that they sat in silence for three months, there were times that they communicated and that Khan made interpretations. He concedes that many of these were mistimed and were felt as failures by the patient, but graduated enough to allow the regression to proceed at its own pace. This ties in with Winnicott's (1971) view of interpretation as a means of establishing the limits of the

analysts understanding and of letting the patient know that they are still there. This seems a tricky path to tread, between not impinging on this silent True Self and knowing how and when to graduate the failure of adaptation. It raises the question of what mechanisms the analyst is using to gauge the regressed patients needs - presumably Khan is not in a state of primary maternal preoccupation, but then how to judge in the heat of the session, whether his adaptation has been good enough? There seems to be a nebulous core at the centre of this technique (regression and holding) that makes it extremely difficult to explain to prospective therapists *what* it is they should be doing at any given moment during a regression. This may be due to theoretical imprecision or it may just be the nature of the phenomenon that is being examined. Leaving these questions to one side for the moment (as we return to them in later sections), let's consider how Khan (1960) sees Mrs X proceeding out of the regression. Khan describes how the period of deep regression to dependence (and the analytic holding involved) followed by the graduated failures, had fostered a growing sense of self in Mrs X and that she was able to relate to him in a far more 'real' manner. He felt that she had a far greater understanding of how her compliance had played out in the various relationships in her life, and that she is tentatively finding herself more able to cope with life. She is shifted into the third phase of treatment by her husband again, this time reneging on their agreement regarding her son coming to stay with her for the holidays. This sets her off into a state where her "mood was flagrantly and solidly paranoid" (Khan, 1960: 162). She rages against Khan, her husband, anyone in the firing line and he feels that she is almost forcing him to hate her. Winnicott (1971) would perhaps see this as an "experience of maximum destructiveness [without which] the subject never places the analyst outside and therefore can never do more than experience a kind of self-analysis" (Winnicott, 1971: 91).For Winnicott, the onus is on Khan to survive these attacks and not retaliate - it also means that he should resist the temptation to interpret the attacks, Winnicott would advise waiting until the "phase is over, and then [discussing] with the patient what has been happening" (Winnicott, 1971: 92). Khan does not exactly follow this to the letter and we will discuss this in a later section, but for now we turn our attention to containment and how it plays out in the clinical setting.

In the introduction to his book, 'Learning from Experience', Bion (1962b) asserts that obscurities exist in his work, but that they "exist because of my inability to make them clearer" (Bion, 1962: ii). In a later work, he elaborates on this further, when he states:

> [T]here is a central abstraction unknown because unknowable yet revealed in an impure form in statements such as 'container or contained' and that it is to the central abstraction alone that the term 'psychoanalytical' element can be properly applied or the sign ♀♂ allocated.
>
> (Bion, 1963: 7)

There is little doubt that the variety of ways in which containment has been interpreted in the literature can be said to be a function of the way in which Bion uses language, and the way in which he circles around this unknowable central abstraction, never fully explicating his views on it lest it saturate our experience. A review of the literature (Britton, 1992; Ferro 2005; Lafarge, 2000; Mitrani, 2001; Steiner, 2000) that has evolved since the death of Bion and which describes containment in the clinical setting reveals a wide array of interpretations of his work that are often substantively different in the way that they apply it and in the way they view the underlying model of mind proposed by Bion (1962b). It is beyond the scope of this paper to critically review these interpretations but it is worth exploring some of them in our investigation of containment in the clinical setting. Cartwright (2009) introduces a useful dichotomy between the way Thomas Ogden (2004, 2004b) and Robert Caper (1999) (as 'dream object' and 'proper object' respectively) view containment and I shall use this as an illustrative tool in my consideration of the case material below. The main difference between these two views turns on their interpretation of what is involved in the process of reverie - in other words, what they make of the countertransference and how they feel it should be acted on (if at all). In simple terms, Caper (1999: 141) proposes that the "object [or analyst] contains or detoxifies what has been projected into it simply by being realistic about it". This involves resisting the pressure exerted by "projective identification to feel like that patient's projected internal object" and this allows the patient to conceive that his projections "might not represent a concrete reality" (Caper, 1999: 142) and may be something that can be tolerated and thought about. In his application of Bion in his clinical work, Ogden (2004b) focuses more on his later work with the emphasis being on the expansion of meaning that can be generated by the patient and analyst, the onus is on the analyst to "create conditions in the analytic setting that will allow for the mutual growth of the container (the capacity for dreaming) and the contained (thoughts/feelings derived from lived experience)" (Ogden, 2004: 1359). The analyst does this by engaging with the reverie provoked by the patient - sifting his own subjective feelings, images, and the thoughts on the periphery of his consciousness as a means of "identifying and holding in mind unassimilated experience" (Cartwright, 2009: 44).

With this in mind, we move on to case material of a session provided by John Steiner (2000) that we will use to illustrate some of the key dynamics of containment. I have chosen this vignette as it captures some of the tension between this idea of the analyst being a proper object and/or being a dream object, and while I will be guided by Steiner's formulation of the material I will add some of my own to draw out the themes on which we are focussing. The patient that Steiner (2000) describes, Mr A, is in his early forties and "mostly functioning at a psychotic level" (Steiner, 2000: 247), who had moved between the care of his family and psychiatric hostels for most of his adult life. Mr A locates the start of his problems at age four when his mother sent him to kindergarten, and that he has never forgiven his mother for doing this. He attended boarding school from the age of 11 where he experienced a breakdown with severe paranoid ideation. He described how his parents failed to rescue him from this situation and, in response, he constructed a "system that he called his visions into which he would escape when the ordinary world became unbearable" (Steiner, 2000: 247). Even though these visions (which contained buildings) are meant to be a place of sanctuary for Mr A, what strikes Steiner about their depiction is the cold emptiness of them and the feeling of lifelessness they engender. This can be seen as a communication about the state of the patients internalised container that strips the goodness and vitality from all that it experiences, indeed Steiner notes that Mr A "behaved as if he were a burnt-out case in which no living thoughts or feelings were to be found" (Steiner, 2000: 247). This is linked to what Bion saw as an internalised breast that strips away all meaning for the infant and "starves its host of all understanding that is made available" (Bion, 1962a: 182). This reminds me of a borderline patient of mine who, whenever an interpretation of mine was felt to have linked us in some way, would start to make less sense as the associations between her sentences loosened. In this one could see an unconscious process where meaning was broken down by her inadequate containing object and the link between us was severed. As part of the process of containment, Steiner is paying attention during most of the sessions to his feelings towards the patient and is sifting these feelings for meaning to emerge out of the sessions. He finds himself becoming furious with the patient when the patient just sits in silence, he then finds these feelings swiftly replaced by pity and concern (which he later feels to be hollow). He sits with these feelings allowing them to circulate in and around his consciousness and what emerges in time (combined with that gleaned from other impressions) is a picture of Mr A's mother who had to put on a loving face while he was a child when in fact she was extremely provoked by his behaviour. In the way that he frames this, one could say that Steiner is acting as both a proper object and a dream object in this scenario - resisting the pressure put on him by the patient's projective

identification by assuming a more realistic role, but also allowing the projections to impact him emotionally and using this impact to make meaning.

In the run up to the session that we are focussing on, the patient had been in analysis for six years, and had recently moved back home from the psychiatric hostel to help tend to his mother who was ill. He admitted to Steiner feelings of power and excitement in this reversal of roles with him having to tend to his mother - this power also plays out in Mr X changing their number of weekly sessions from five to three and Steiner portrays him feeling "justified and in control" (Steiner, 2000: 248). I have reported the session at length below because it is in the interchanges that containment is demonstrated. Mr A's first words in the session [which is a made up session, on a different day] are 'The visions are a suitable habitation for a control freak', and Steiner notes how he often uttered random, seemingly disconnected remarks and then was silent during which the analyst was expected to find some meaning in them. Steiner is unsure what he means at first but by using his intuition he links it to feeling less in control about coming on a different day. Mr A is at first silent, then responds with 'I have to accommodate to the real world so that I can stay alive', to which Steiner responds by suggesting "that he preferred the visions, where he was in control" (Steiner, 2000: 248). Mr A then talks about his visions and Steiner enquires whether the visions are like dreams, he responds by saying 'Perhaps; there are bellows', then after a pause: 'Like fanning a spark of life'. Again, Steiner is unsure about what these statements mean but links it back to the cold and empty buildings of the visions and suggests that Mr A is implying that their work together is keeping something alive inside. Mr A replies with 'You would call the fire brigade if the place caught fire', to which Steiner interprets his anxiety that Steiner might be too interested in things going on inside and that things might spiral out of control. Mr A then says that he wished he hadn't said anything about the bellows, and Steiner interprets this as a way of attacking the link between them. After some silence, Mr A says that he had to resort to the visions when caring for his mother became too taxing, "but the trouble was that in turning to the visions he can play God" (Steiner, 2000: 248). Steiner interprets this as his fear of his omnipotence to which Mr A replies that it is not only a fear of being God but a fear of being the Devil as well.

In unpacking how containment comes about through this exchange one is struck by the substantial amount of anxiety that the patient is feeling. Steiner is presented with fragments laden with anxiety that he has to cope with and try and make meaning of them. In his reverie, Steiner is able to tolerate

the anxiety with which these fragmentary communications are imbued and then is able to introduce possible meanings into the analytic space through interpretation. By giving voice to Mr A's anxieties as the session progresses he certainly increases the patient's anxiety, but what he also does is make these ideas (and the phantasies on which they are based) into the stuff of thought, demonstrating that they are something that can be tolerated, worked through, and understood. Through interpreting and containing Mr A's anxieties, Steiner forges a link between them during the session - Mr A then tries to attack that link (by regretting mentioning the bellows) to which Steiner interprets how dangerous, provocative, and frightening this link must feel to him. This leads Mr A to consider the nature of his split (God and the Devil) and softens the catastrophic nature of his unconscious omnipotent phantasy. With each step of containment through this session, Mr A seems to become more capable of containing (and hence thinking about) his own anxieties. Interestingly, Steiner sees some enactment in his conduct of this session, he sees his meaning making on behalf of the patient as allowing the patient to find refuge in a 'psychic retreat' (Steiner, 1993) in which his "emptiness, deadness and despair could be evaded" (Steiner, 2000: 250). While he defensively evades thinking about his experience, Steiner has to do his thinking and meaning making for him. This self-criticism would seem to link to the idea of analyst as dream object mentioned above - this pole of containment would recommend tolerating the anxieties and uncertainties in the analytic setting without grasping at meaning too soon, allowing meaning to accrue over time in the interaction of subjectivities (Cartwright, 2009). This could have perhaps been achieved by using his own concept of 'analyst-centred interpretations' (Steiner, 1993) where the analyst gives the patient a sense of the ways that he or she is experiencing the analyst - what this does is provide a point of contact between the patient and analyst and opens up a space where meaning can evolve between them. To his credit, Steiner (2000) acknowledges the protection that his meaning making affords both him and patient. However, one wonders if he is not being harsh on himself; it seems a fine line to judge being able to make use of projective identifications and one's countertransference while retaining a mind of one's own, and at the same time remaining emotionally available to one's patients (especially when they are psychotic, like Mr A). In his defence, it could be said that Mr A was actively attacking the link during the session, destroying an awareness of external reality through the envious action of -K (Bion, 1962b).

The focus of this chapter has been a comparison of the developmental theories of Bion and Winnicott with a specific focus on their concepts of containment and holding respectively. This then lead into a critical evaluation of two case vignettes that were provided as an illustration of holding

and containing respectively in the clinical setting. As can be seen from both vignettes discussed, there are many questions raised by the different techniques and their application to Mrs X and Mr A. Steiner (2000) spends much of his article questioning whether his interventions were correct in their content and timing, and he is paying attention to the pressures being put on him enact certain roles. In contrast, during the regression proper Khan (1960) seems to be guided by a baseline injunction that he not violate Mrs X's True Self by making interpretations. But he doesn't seem to be doing this all the time, at times he admits that he is able to freely make interpretations to her. Hence, it is us that are left with questions as to how he knows when it is right to interpret, by what mechanisms is he aware what these interpretations should look like and when they will be appropriate? These are questions that we will try to answer in the next chapter.

Chapter 5 - Discussion

In the previous section we compared the concepts of holding and containing at first from the perspective of how they describe the developmental trajectory of the infant, and then through the use of clinical vignettes we charted how they are applied in the this setting. This last focus provides some sense of the substantial differences between holding and containment. In order to draw out these differences further we will now evaluate the case vignettes described in the previous chapter with 'the boot on the other foot', to paraphrase Steiner's (2000) Mr A. In other words, the previously examined case material described by Steiner (2000) will be further evaluated from the perspective of Winnicott, and the case described by Khan (1960) will be evaluated from the perspective of Bion.

The case of 'Mr A' (Steiner, 2000) takes on a very different hue when viewed from the perspective of Winnicottian theory. From this perspective, the long silences where Mr A lay motionless on the couch, that so characterised his analysis would be a hint that this patient is involved in a form of regression to dependence. Where Steiner (2000) saw the patient wasting his life and wasting the analysis, Winnicott (1954a) would have seen himself (as the analyst) being used in a growth promoting and primitive way. The feelings of power and excitement that Mr A feels in tending to his mother could be seen in two ways from a Winnicottian perspective: firstly, it can be seen as providing coherence to a False Self (or Caretaker Self) (Winnicott, 1960b) that is energised by the old habit of having to care for itself and having to comply because of the mothers fallibility. Secondly, this omnipotence which Steiner (2000) casts in a negative light as a means of attacking the link between patient and analyst, may also be seen as the regressed patients need for brief experiences of omnipotence to help with integration while the analyst is still (at some level) subjectively perceived. It is more likely that the excitement shown in tending to his mother corresponds to the first perspective, whereas the omnipotence shown in the session corresponds to the second perspective.

Steiner's (2000) interpretation of Mr A's omnipotence is felt by him to be an impingement, and this comes out in his next comment when he says: 'I have to accommodate to the real world so that I can stay alive'. From a Winnicottian perspective this could be seen as a clear indication of the presence of a False Self, one that has had to comply with the demands of the world in order to protect a True

Self that was presumably felt to be under intense threat from infancy. Mr A's comment about 'bellows' and 'fanning a spark of life' can be seen as a communication about the existence of the True Self that is vulnerable and under threat, but does have some hope. From the perspective of Winnicott, Steiner's (2000) interpretation that Mr A seems afraid that Steiner is too interested in what is happening inside of him and that it might spin out of control is near to the mark, but for the wrong reasons. Although Steiner and Winnicott might agree that this *is* how the patient is feeling, Winnicott would likely assert that this is exactly the reason why no interpretation should be made at this point. What Steiner is in touch with is Mr A's non-communicating self, the "personal core of [his] self that is a true isolate" (Winnicott, 1963: 182) that should remain inviolate.

From a Winnicottian perspective, Steiner (2000) is right when he recognises that something is 'coming alive' inside Mr A, it is the spontaneous gesture of the True Self which is emerging during a regression after 6 years of analysis. Steiner asks the question: "Should I try to make links and find meaning or should I stay with the experience of fragmentation and discord, which gave the impression of a destroyed and meaningless internal world?" (Steiner, 2000: 249). It is likely that Winnicott would have encouraged the latter, allowing the patient to remain in this regressed and unintegrated state, heavily dependent on the analyst. But yet again, one is left with little sense of *what* the analyst should be doing to facilitate this - as mentioned previously, Winnicott is vague on what this adaptation to the patient's needs looks like. The clearest sense one can get about what the analyst should be doing comes from 'Withdrawal and Regression' where Winnicott (1954b) gives examples of interpretations (used sparingly) that describe the holding capacity of the analyst and the setting. So, from this exercise one can see that there are fundamental differences in the way that the one would formulate this case from the perspective of Winnicott, and this vastly different formulation suggests clear differences in clinical application. Even though, from reading Winnicott, it is difficult to pin down *exactly* what analytic holding looks like it is clear that he would have a problem with the way that containment (as demonstrated by Steiner (2000)) plays out in the analytic setting.

The case of Mrs X presented earlier, found in the work of Masud Khan (1960), provides some fertile ground to profitably compare holding and containing. As Khan notes, the first phase of the treatment more or less conformed to a classical course and so there is little (from the perspective of containment) that is controversial in that early sequence. It is toward the end of that first phase that

one might begin doing things differently from the perspective of containment. From this perspective one would view the interpretative work that Khan has done (interpreting her aggression, her ambivalence, etc) as having forged a link between Khan and Mrs X and this link is breeding an awareness of reality that is causing her some considerable discomfort. The containing that has been provided so far has made it more possible for her to think about her aggression, but this comes at a price as she starts to experience some depressive feelings (evidenced by her state of irritation and withdrawal). This launches her into a mania, the aim of which is to destroy the link between them through her omnipotence - she floods the sessions with her dreams and associations and insists that Khan interpret them. This is linked to what Ogden (2004) calls 'pathological containing', a plethora of dreams and images that flood the analytic space and by their sheer volume disturb the analyst's capacity for reverie and reflection. Bion (1962b) would see this flooding as the envious work of -K. To be fair, Khan (1960) does recognise that her mania is an escape from depressive feelings but at the high point of her mania when she steals the books and presents them to him, his fidelity to holding prescribes a course that is substantially different to one that containment would follow. Khan doesn't interpret the incident with the books, preferring to hold her in this situation - what this amounts to is not retaliating and allowing the chaos of her actions to find a safe space in which to exist and find some measure of integration. By Khan's account, this analytic holding does sober her somewhat, leading to a diminishment of her mania. However, containment would attempt to go further than this - from this perspective one would likely interpret the aggression in her act and, crucially, how it is directed at the person of the analyst. This would open up the space for aggression (so much a feature of her clinical picture) to be talked about and thought about in a very live and present way.

Robert Caper's (1999) critique of holding seems very prescient at this point; his view is that in holding the "analyst identifies with the patient's state of mind, and conveys to the patient that he has done so", but that containment goes one step further and "presents the patient with an object that [through the use of interpretation] has gone beyond identifying with him" (Caper, 1999: 154). Caper feels that while this introduces a feeling of insecurity into the analytic setting, it also greatly reduces the omnipotence of the patient's phantasies through the analyst positioning himself as a proper object, distinct from the patient. In my opinion, there is a sense in Khan's description that he is colluding with the patient's internal world by not engaging with the aggression in her act. In a session soon after the break and the stealing incident (when she is supposedly in the regression proper), the patient brings out a picture of her childhood nurse. In contrast to the earlier idealized

portrayal of her, she is now presented as a “fat and listless person” whom “the patient now experienced as having been very destructive in [her] passivity towards all that was vital and aggressively emergent in the growing personality of the child” (Khan, 1960: 152). This could be viewed as a transference communication about how the patient really feels about how Khan handled the stealing incident, while his reaction at first settled her (because he didn’t become her aggressive retaliating mother in the transference), his silence transforms him into the ineffectual childhood nurse in the transference. An object that could survive her aggression without retaliating but not engage with it in a way that could provide an experience that could be learnt from and could help transform it. From the perspective of containment, her regression to dependence looks very much like a massive depression. This then begs the question: if a space had been consistently provided from early on in the analysis where her aggression could have been thought about, worked through and transformed, would her depression have reached the depths that it did?

Chapter 6: Conclusion

From the discussion in the previous chapter we can see that there are profound differences in the way that containment and holding can appear in the clinical setting. In addition to this, our discussion in the first section of Chapter 4 showed that there are substantial differences in the models of mind and the developmental theories that underpin these two concepts. But is this a difference that actually makes a *difference*? Are we, as Ogden (2004) would have it, merely viewing the same analytic experience from different perspectives? In my opinion, it does make a difference. I hope that it is clear from the preceding chapters that the theoretical differences between them *do* lead to substantial differences in clinical practice. And further, I believe that the lack of clarity over what (as the analyst) one is actually doing while performing the holding role during a regression creates a situation where enactments and boundary transgressions can escape notice.

In his critical review of current debates surrounding enactment, Ivey (2008: 22) states that "enactment may also manifest in the analyst's experience of *inhibited* responsiveness to the patient". That it is not just the things that the analyst says or does that may be construed as an enactment, that it may be present in what they often don't say or do. There is a sense of this 'absence as enactment' in the phase of Khan's (1960) treatment described above. In 'Playing and Reality', Winnicott (1971: 117) has this to say: "Psychotherapy is not making of apt and clever interpretations; by and large it is a long-term giving back to the patient what the patient brings. It is a complex derivative of the face that reflects what is there to be seen". There seems to be a blanket injunction in this that analysts should provide a space in which the spontaneity and creativity of the patient can emerge, as far as possible, unhindered by the subjectivity of the analyst. But how realistic is this? Winnicott (1960c) himself admits that psychotic and borderline psychotic patients have a profound impact on the analyst, but one is hard pressed to find in his work detailed descriptions of how this effect plays out in his sessions. We have his paper on 'Hate in the Counter-transference' (1947) but this seems quite two dimensional in its apprehension of the subject, simply asserting that the well analysed analyst should be able to objectively decipher the love and hate engendered in him by the patient and be able to cope with these feelings of hate. In his paper on 'Counter-transference' Winnicott (1960c), relates an incident where a patient physically hit him because of something that he said, he won't say what it was that he said but describes it as a

'reaction' to what the patient had originally said and done, not countertransference. In a similar vein, Khan (1960: 136) has this to say about countertransference in the context of Mrs X:

> I do not mean here the conflictual unconscious transference in the analyst. I am not pretending that such experiences during this treatment were absent from my relationship to the patient. But I do not think that one gains anything from confessing them to an impersonal audience any more than one would were one to confess them to the patient. By counter-transference, therefore, I mean the conscious and total sensitivity of the analyst towards the patient.

It is worth noting that Khan went on to engage in a number of extreme boundary transgressions with his patients (Goldman, 2003), which might incline us to retrospectively doubt Khan's depictions of countertransference experiences. However, in terms of these vignettes, there seems to be an old-fashioned veil of silence drawn over their personal reactions in these two instances and an assumption that whatever those reactions were they didn't interfere in the therapy to the extent that they required elucidation.

At the core of this veil of silence lies the concept of the "good-enough mother" and her state of "primary maternal preoccupation". From a developmental perspective, Winnicott's (1960a) notion of the infant as absolutely dependent on the mother during a holding phase where she adapts to the infants every need is plausible - so is the idea that the infant in these early stages is not communicating primitively through projective identification. However, in my opinion this creates a blind spot when the theory is translated into clinical practice - Winnicott's inability to countenance that the infant during the holding phase *might* be communicating translates into a decreased awareness during 'regressions' of what effect the patient might be having on the analyst and what meaning these effects can have. In a general sense, Winnicott's (1971) injunction that analysts should avoid unnecessary interpretation and keep silent more often than not, is good advice. However, what this misses is a thoughtful awareness of what these silences are communicating to the patient, what part are they playing in the enactment of the patient's inner world? Since Bion (1962b) introduced the concept, containment has been interpreted in many different ways by analysts and this has led to a variety of ways in which it can be applied in clinical practice (Cartwright, 2009). However, at the heart of the concept lies the notion of "reverie" which at its most basic level encourages analysts to be aware of their own internal milieu, to be aware of the effect that the other person in the room is having on them. While there may be substantial

differences of opinion between analysts about how one's subjectivity and countertransference are to be apprehended and dealt with (Ivey, 2008), it seems better to at least to be thinking about it.

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