



**The Maternal Metaphor: An exploration of Winnicott’s ‘holding’ and
Bowlby’s ‘secure base’ in the therapeutic relationship**

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“It has often been assumed that animals were in the first place rendered social, and that they feel as a consequence uncomfortable when separated from each other, and comfortable whilst together, but it is a more probable view that these sensations were first developed in order that those animals which would profit by living in society, should be induced to live together, for with those animals which were benefited by living in close association, the individuals which took the greatest pleasure in society would best escape various dangers; whilst those that cared least for their comrades and lived solitary would perish in greater numbers” (Darwin, 1871).

“A thing which has not been understood inevitably reappears; like an unlaidd ghost, it cannot rest until the mystery has been resolved and the spell broken” (Freud, 1909).

“Always we are being reflected in the eyes of others” (Athill, 2008, p. 84).

ABSTRACT

This paper is a theoretical study exploring Winnicott's concept of 'holding' and Bowlby's concept of 'secure base' and their implications for the therapeutic relationship. Particular attention is given to the parallel maternal metaphor in both providing a 'holding' environment and a 'secure base' in the role of a therapist. This paper further explores how Attachment Theory echoes and expands upon Winnicott's work with a particular focus on John Bowlby's work. Bowlby posits that the secure base provided by the mother in infancy mirrors the manner in which a therapist provides a secure base for clients to facilitate internal exploration. The secure base mirrors Winnicott's concept of 'holding' which also facilitates exploration and ultimately, the move 'towards independence', both in early relationships and the therapeutic dyad. This paper includes an exploration of the research on these concepts and concludes with an examination of the convergences and divergences between Winnicott and Bowlby as theorists, both personally and professionally, and a critical examination of the implications for the use of both theories in practice. It is hoped that examining the parallel maternal metaphor within these theoretical frameworks will further illuminate the inner workings of the therapeutic relationship and ultimately, the primacy of human connection and relationship.

INTRODUCTION

Winnicott and Bowlby's developmental theories were born out of a rejection of psychoanalytic drive theory and a move towards a recognition of the influence of the external environment on development (Issroff, 2018, p. 15). Both theories foreground the centrality of early maternal care in providing a specific environment integral to healthy psychological development. The failure of this care would have lifelong implications. Thus, both theorists sought to understand what makes a good therapist through the lens of what makes a good mother (Holmes, 2006, p. 104).

Winnicott's 'holding' and Bowlby's 'secure base' are concerned with a particular rubric of maternal care encompassing both innate factors and environmental provision. The provision of a 'holding' environment and a 'secure base' constitute a collaborative process of development between both the mother-child and therapist-client relationship. The environment provided by maternal care, both in childhood and the therapeutic relationship, provides an emotionally safe place which facilitates the exploration of the inner psychological world (Slochower, 1996a).

This study will first introduce Winnicott's theories on child development with a particular focus on the 'holding' environment and the role of the maternal metaphor. The paper will then turn to Bowlby's development of Attachment Theory which echoes Winnicott's ideas of the significance of early relationships and the primacy of attachment to a primary caregiver. The developmental trajectories that underpin the concepts of holding and secure base are explicated, demonstrating both the similarities and differences between these two concepts. The research seeks to draw together elements of both theorists to attempt to gain a further understanding of what is at play within the therapeutic relationship within these concepts, with a particular focus on the aspect of the maternal metaphor. The paper concludes with a critical discussion of the implications of both concepts in practice with a specific focus on the maternal aspect of the therapeutic dyad for the purposes of further illuminating the phenomenon of therapist as mother. This dissertation was inspired by a curiosity of what is fundamentally at play between therapist and client within the provision of a holding environment or secure base, particularly the concept of therapist as mother.

CHAPTER 1 – WINNICOTTIAN CONCEPT OF HOLDING

Holding is “the basis for what gradually becomes a self-experiencing being” (Winnicott, 1966, p. 7).

Winnicott’s theory implies an instinctual quality to the infant’s physical and emotional development and also to the maternal care which facilitates this development (Winnicott, 1960). Winnicott believed simply that if a child is given the right environment, physically and emotionally, it has an innate capacity to develop and reach for independence (Winnicott, 2002). Central to Winnicott’s developmental theory is the concept that an infant journeys from ‘absolute dependence’, through ‘relative dependence’, to ‘towards independence’ (Winnicott, 1960). The dependence was so that “there is no such thing as an infant” (Winnicott, 1960). During ‘dependence’, the baby cannot exist without the environment on which it depends, prototypically, maternal care. The maternal care or ‘holding environment’ provided the arena for the maturational processes to drive this trajectory.

Winnicott viewed holding as an integral part of facilitating the trajectory towards independence, culminating a sense of self and the ability to relate to others (Casher, 2013). However, Winnicott perceived independence as ‘never absolute’. A healthy developmental trajectory proposes that an individual ultimately has an interdependent relationship with his environment and does not live in isolation (Jacobs, 1995, p. 38). Winnicott, using object relations theory as a base, recognised the relationship as an open system and placed the ego in relation to its environment (Chescheir, 1985).

Winnicott described early maternal care as ‘primary maternal occupation’ where the mother is innately, highly attuned to the infant and its needs from pregnancy through childhood (Winnicott, 2002). Primary maternal occupation helps create a ‘holding’ environment for the infant which does not simply constitute physical holding but also emotion regulation, a “total environmental provision... all that a mother is and does” (Winnicott, 1960). He conceptualised holding as the provision of ego support provided by maternal care in infancy which facilitates the illusion of omnipotence that allows the infant to develop (Jacobs, 1995, p. 39). In essence, the mother’s perceived omniscience facilitates

the infant's perception of his omnipotence. The complexity of the "innumerable subtle things" that provide a safe, reliable holding environment facilitates a dependent state which provides for the infant's ego integration, aptitude for object relating and ultimately, ability for object usage (Winnicott, 1960) (Masterson, 2013).

Winnicott famously coined the term the 'good enough mother' which encompasses the paradoxical nature of the mother's ability to be wholly available to her child whilst simultaneously being humanly unreliable (Winnicott, 2002, p. 234). The imperfection of human nature provides the perfect environment for the child's move 'towards independence'. Winnicott vehemently connected "good enough" maternal provision and mental stability later in life and explains "... the mental health of the individual is being laid down from the very beginning by the mother", she "... is laying down the foundations of the individual's strength of character" (Winnicott, 2002, p. 25).

The Transitional Object and the move Towards Independence

Winnicott distinguished between object relating and object usage as relationships between subjectively conceived objects and objectively conceived objects (Winnicott, 1960). The object, for example a teddy, toy or doll, helps the child recognise 'not-me' possession and the existence of an external reality (Winnicott, 1953). The transitional object is not part of the infant but is not wholly separate either which forms a bridge to relating to the outside world (Driver, Crawford, & Stewart, 2013, p. 198). The child begins to distinguish between inner reality and external life, between fantasy and fact (Winnicott, 1953). The transitional object is adopted by the infant to allow him tolerate the mother's failures as her adaptation lessens in accordance with his growing maturity (Masterson, 2013). The infant's ability to recognise the object's externality develops through the holding environment and eventually becomes deattached as the 'transitional space' (Winnicott, 1960). The infant's experience of its internal and external world, is later filled with creative pursuits and cultural

interests (Winnicott, 1953). Thus, the transitional object ultimately assists the child's emotional development and move towards independence.

The transitional space in adulthood is just as significant, particularly in the therapeutic relationship, where the therapist's interest in and responsivity to the client's emotional needs facilitates the client's capacity to 'play' with fantasies, ideas and possibilities of being in the world (Safran & Muran, 2000, p. 95). The 'transitional phenomena' enable a client to move towards a "capacity to play... with its own independence and autonomy" (Winnicott, 1969). Thus, as the mother's ego is utilised by the infant, so is the therapist's ego used by the client. This process cannot take place without the provision of an appropriate holding environment (Winnicott, 1969).

The True and False Self

An important aspect of Winnicott's examination of the potential outcome of the holding environment is the development of the True and False Self. The True Self is the infant's inherent potential or the core of the personality (Slochower, 2018, p. 99). The False Self develops when the holding environment has been insufficient and results in the development of character disorders, failures of self-establishment or self-discovery (Winnicott, 1969). The function of the False Self is a set of capacities to cope with the world, a pseudo-independence and pseudo-maturity employed to replace parental absence and veil needs, whilst simultaneously defending against the anxiety of the annihilation of the True Self (Winnicott, 1960) (Slochower, 2018, p. 104). The holding environment facilitates a regression in the therapeutic relationship where dependency needs re-emerge. This subsequently allows the emergence of the True Self, the source of authenticity in a person (Safran & Muran, 2000, p. 92). All individuals develop a False Self, but it is its pervasive presence of unreality and obscurement of the True Self that is significant (Safran & Muran, 2000, p. 93).

The Maternal Metaphor: Therapist as Mother through Winnicottian Theory

“At the deepest level, psychotherapy is replacement therapy, providing for the patient what the mother failed to provide at the beginning of life” (Guntrip, 1977, p. 191).

Winnicott applied his theory of holding to both the dyadic mother-infant and therapist-client relationship and believed passionately in the therapist’s reparative potential. This potential allowed the client to regress and re-experience and repair trauma within the safe, responsive and empathic relationship in the presence of a reparative, symbolic maternal figure (Slochower, 2018, p. 104). The client can become a baby again but this time with a more responsive mother. The therapist becomes like a ‘good enough mother’ providing a compensatory healing space to allow the client to address previously unmet ego needs, facilitate psychic development and nurture the True Self (Driver et al., 2013, p. 14).

However, aspects of Winnicott’s theory of holding and the protective function of the therapist have been criticised for being too idealised (Jacobs, 1995, p. 119). He presents holding as ‘requiring an almost superhuman sensitivity, patience and tolerance’ which both idealises the function of holding and the therapist herself (Lomas, 1993, p. 87). Just as there is ‘no such thing as a baby’, there is also “no such thing as a therapist or a client, only a therapeutic dyad” according to Joan Berzoff (Berzoff, Melano Flanagan, & Hertz, 2011, p. 225). The client and therapist are in an intersubjective relationship with one another – “The therapist impacts the client and the client impacts the therapist” (Berzoff et al., 2011, p. 234). Berzoff states that the holding experience is not unidirectional as in Winnicottian theory but is the product of intersubjective interaction – we exist only in connection with one another (Berzoff et al., 2011, p. 224).

CHAPTER 2: BOWLBIAN CONCEPT OF SECURE BASE

Attachment theory is “one of the fundamentals of what makes us human” (Bowlby & King, 2004, p. 11).

John Bowlby, although a Psychoanalyst, frequently drew from evolutionary biology, ethology and systems theory which informed key concepts of his developmental theories (Howe, 2011, p. 7). Although his admiration for Freud never wavered, his first and most abiding influence was Darwin (Holmes, 1995). In Darwin’s view, mammals are social by virtue of evolution and as a result are born with an innate biology of attachment (Brockman, 2007). Like Winnicott, Bowlby believed that the external environment was pivotal in a child’s development, particularly in interactions between the infant and mother (Bowlby, 1969a, p. 24). He believed humans were instinctually motivated to survival behaviours of “nutrition, safety and reproduction” (Bowlby, 1969a, p. 124). Similar to Winnicott, he also moved away from psychoanalytic drive theory and adopted an evolutionary perspective on emotional development and psychopathology (Bowlby, 1988, p. 29). Bowlby’s attachment theory is an ‘autonomous motivational system’ as opposed to behaviour derived from sexual or aggressive drives (Gullestad, 2001). Holmes describes this as “where I am in relation to my loved one becomes the key issue, rather than what I can do or have done to me” (Holmes, 1995).

Attachment theory is concerned with the interplay of ‘attachment behaviours’ between caregiving and care seeking in a relationship – it is interpersonal, rather than intrapersonal (Holmes, 1995). An individual’s safety and survival is directly related to the instinctual bond between infant and their primary caregiver termed, ‘attachment figure’ (Howe, 2011, p. 5). The proximity of this relationship provides protection and security for the infant. Attachment bonds are not described in terms of their strength, rather their quality: secure or insecure. These attachment styles would be further categorised into several subtypes (Main & Solomon, 1986).

Attachment behaviour refers to any behaviour that is engaged in with the sole purpose of obtaining or maintaining proximity to "some other clearly identified individual who is conceived as better able to cope with the world" (Bowlby, 1988, p. 29). Attachment behaviour is exhibited by an infant coupled with the attachment figure to whom he is ensconced. As children mature to adulthood, attachment behaviours are less concerned with physical proximity and more concerned with relational, emotional and psychological proximity (Kerns & Richardson, 2005, p. 73). Although attachment behaviour is most clearly recognised in childhood, it continues to play out throughout adult life where attachment figures typically become romantic relationships, friends, siblings and indeed, therapists (Holmes, 2015). Farbert, Lippert and Nevas (1995) conclude that the therapeutic relationship is the ideal arena for clients to display and explore attachment behaviour, particularly through the 'secure base' that is provided by the therapist. Indeed Bowlby (1988, p. 159) maintained that unless a therapist can provide a secure base for their client, therapy cannot even begin.

Secure Base

The secure base describes the environment provided by the attachment figure within a dichotomous relationship which allows for curiosity, exploration and risk (Holmes, 2006, p. 70). This in many ways echoes the Winnicottian holding environment (Bowlby, 1988, p. 159). The secure base is an invisible radius in which the child feels safe to play and explore in the absence of threat. When the child returns to the attachment figure, he is nourished emotionally and comforted if distressed (Bowlby, 1988, p. 12). As the infant uses the mother as a secure base for exploration, so does the client use the therapist as a secure base to discover new ways of being in the world. This security produces a strong therapeutic relationship where the therapist provides constancy, availability, sensitivity and responsiveness (Farber et al., 1995). A client's ability to benefit from therapy is based on his ability to develop a secure attachment to the therapist which in turn facilitates his exploration and growth (Marmarosh et al., 2014).

If positive attachment experiences provided by the therapeutic relationship can be internalised, through reparative enactments of early attachment experiences, the client begins to build his own secure base and can develop ‘earned security’ (Holmes, 2015). From this base, the client is able to form less anxious attachment relationships outside the therapeutic relationship and feels more secure in himself (Holmes, 2006, p. 152). This is largely facilitated by the therapist’s attunement, the ability to hear, see, sense and respond to the client in a way that he feels genuinely seen, felt and understood (Slochower, 1996b). Bowlby named this process ‘earned security’ however, Fear has proposed it be termed ‘learned security’ to honour the commitment and learning the client undergoes in order to create an internal secure base and a relearning of a ‘dominant attachment schema’ (Fear, 2017, p. 51).

Internal Working Models

Bowlby proposed that internal working models are formed by infants of themselves and others during early interactions with attachment figures (Simpson & Campbell, 2013, p. 294). Internal working models are internal templates or schemas based on repeated patterns of interactive experiences which a child stores and uses to predict and relate to the world (Holmes, 2006, p. 78) (Berzoff et al., 2011, p. 193). A securely attached child will store an internal working model of a responsive and reliable caregiver whilst simultaneously holding a self that is worthy of love and attention. Conversely, an insecurely attached child may view the world as unsafe and be cautious of others whilst simultaneously seeing himself as ineffective and unworthy of love (Holmes, 2006, p. 78). Thus, the child holds two simultaneous working models, a ‘self-model’ of how he perceives himself and a ‘relational self’ that represents how he relates to others in significant relationships (Simpson & Campbell, 2013, p. 294). Internal working models are deemed ‘fundamental building blocks of normal and disrupted development’ (Fonagy, Luyten, Allison, & Campbell, 2016). They function unconsciously and have a significant impact on later relationships in terms of interpersonal expectations and behaviour (Berzoff et al., 2011, p. 193).

Maternal Metaphor: Therapist as Mother through Bowlbian Theory

“All of us, from the cradle to the grave, are happiest when life is organised as a series of excursions, long or short, from the secure base provided by our attachment figures” (Bowlby, 1988).

Bowlby likens the therapist’s role to that of a mother ‘who provides her child with a secure base from which to explore the world’ (Bowlby, 1988, p. 159). He also draws the parallel to Winnicott’s concept of holding by describing therapist qualities of being ‘reliable, attentive and sympathetically responsive to his patient’s explorations’ (Bowlby, 1988, p. 159). As in Winnicottian Theory, these qualities of attunement provide the client with responses of care and affection that may not have been received in childhood. Although there are multiple commonalities between the mother-infant and therapist-client dyad, there are also very stark differences. The therapist-client relationship is mediated by ‘unique temporal, financial, structural and ethical boundaries that render it significantly different from childhood attachment relationships’ (Farber et al., 1995).

Bowlby did not see attachment as permanent, but rather enduring unless a specific behaviour, interaction or event changed it. The pattern of interaction ‘becomes increasingly a property of the child himself’ (Bowlby, 1988, p. 127). When individuals seek therapy they are distressed and their instinctive need to feel safe is not being met. Therapists are in a natural position to fulfil the role of an attachment figure providing emotional availability, a comforting presence and regulation of affect to facilitate attachment to develop (Sable, 2004). For Bowlby, the therapist is a companion in the client’s exploration of himself and realisation of the true nature of the models that underlie his thoughts and emotions so that he may begin to restructure them (Bowlby, 1988, p. 172).

An individual’s internal working model conserves their past secure base experience yet also leaves the door open for reconstructing models in light of new significant experience (Waters, Crowell, Elliott, Corcoran, & Treboux, 2002). The joint task of therapist and client is to understand the origins of a client’s dysfunctional internal working models in order that they may be revised through their activation, transformation and resolution (Bretherton, 1992). Over time, the client will develop an

internal working model for the therapist which eventually acts as an impetus for change and can be applied to external relationships (Obegi, 2008) (Harris, 2004) (Parish & Eagle, 2003). The emotional communication and connection between therapist and client is a crucial aspect of ‘constructing and reworking working models of the self’ (Bowlby, 1988, p. 177).

CHAPTER 3 – DISCUSSION

Personal and Professional Parallels

Bowlby and Winnicott shared many close historical links and the same personal and academic backgrounds. Both Winnicott and Bowlby were born in Britain only eleven years apart and were brought up in typically British middle class families. They both studied medicine followed by psychoanalysis and became child analysts. Through their understanding of normal developmental processes as paediatricians, they began to formulate ideas of psychopathology (Holmes, 2006, p. 104). They were both largely influenced by Freud however, it was their mutual Darwinian influence that ultimately drove them to reject psychoanalytic drive theory in recognition of the influence of the external environment on psychological development (Issroff, 2018, p. 15). Bowlby and Winnicott created a different kind of child and mother for psychoanalytic contemplation, emphasising the child's inherent potential, rather than unconscious conflict and drives. Slochower (2018) termed this the beginning of a 'clinical revolution'.

As a result of their similar early experiences, upbringings and psychoanalytic and medical trainings, their theories have much in common. However, despite working toward what appeared to be the same end, Winnicott frequently criticised Bowlby's use of science and ethology at the expense of clinical case study and observation (Fonagy et al., 2016). Winnicott's developmental theories remained focused on the internal subjectivity of the infant whereas Bowlby's focus shifted to the external environment – Winnicott looked from the inside out, Bowlby looked from the outside in (Boyle Spelman, 2013, p. 128). Bowlby says of Winnicott, "Donald and I really had the same task, bringing home the importance for the child of the real external environment; only our approaches were different. He was the poet of the two, I the scientist" (Spelman & Thomson-Salo, 2014). Winnicott was a metaphorical, imaginative therapist and writer whose work was more based on intuition and observation rather than science (Jacobs, 1995, p. 142). Issroff describes Bowlby as an "avid ornithologist and ethologist" and Winnicott a "watcher of humans" (Issroff, 2018, p. 16).

It seems Winnicott and Bowlby brought their early history, wishes and needs into their professional trajectory, particularly perhaps for a reparative, emotionally present maternal figure (Slochower, 2018). Both Bowlby and Winnicott had troubled relationships with their mothers and their fathers were largely absent. Winnicott's mother suffered from depression and his father, a successful clothing merchant, was largely absent (Spelman & Thomson-Salo, 2014). Sir Richard Bowlby's (2004) lecture describes his grandmother, Bowlby's mother, as "cold, remote, formal and distant" and his father, a highly renowned surgeon, was also largely absent (Stroebe & Archer, 2013). Interestingly, Winnicott and Bowlby both shared the same analyst, Joan Riviere and supervisor, Melanie Klein, both strong, powerful women (Boyle Spelman, 2013, p. 6). Through these relationships, Holmes believes Bowlby was attempting to reconcile his own relationship with his mother whilst also appealing to his absent father (Holmes, 1995). Perhaps Winnicott and Bowlby analogously sought their own reparative maternal environment in their analyst and supervisor, both "highly intelligent", though "tough, forceful, no-nonsense" women (Holmes, 2006, p. 78). Certainly, their preoccupation with the maternal metaphor is a common thread in both their theories.

Theoretical Convergences and Divergences

Although Bowlby and Winnicott both premised maternal care in healthy mental development, they have slightly differing views on how this is provided. Winnicott's holding environment is a physical and mental space created by the mother in her 'primary maternal occupation'. Bowlby's secure base is the atmosphere of a secure, predictable and protective relationship. Winnicott's mother mediates stimuli between the child's internal and external world in a form tolerable to the child for his subjective internalisation. Bowlby's mother provides a protective barrier between the child and its external world, however the child plays an active role in this interaction by displaying attachment behaviour. Winnicott emphasised the introjection of an ego supportive environment and the resulting 'capacity to be alone' which is a clear parallel of Bowlby's secure base and resulting secure attachment (Holmes, 2015) (Eagle, 2003).

In the therapeutic relationship, therapists serve to provide correctional or reparative experiences for the client. Through Winnicottian theory, this is done through the client regressing and re-enacting past trauma in the presence of a reparative therapist. For Bowlby, again the focus is more relational, internal working models created by the client can transform within the therapeutic relationship and are then extended to relationships outside the therapeutic sphere. Both theorists are concerned with the importance of exploration, however Bowlby's exploration takes place in the external environment while Winnicott's exploration is concerned with inner exploration. Holmes posits that both forms of exploration are simultaneously at play (Holmes, 2006, p. 141).

Separation Anxiety

The attachment system is an ongoing appraisal of physical and psychological threats to the environment, attachment figure and ultimately internal working model (Simpson & Campbell, 2013, p. 294). The human fear system functions to identify threat in the environment while attachment behaviour functions as protection (Kerns & Richardson, 2005, p. 74). This process naturally triggers feelings of fear and anxiety which can persist in adulthood. Sable (2004) further posits that the excessive anxiety of PTSD is a clear representation of attachment behaviour, where proximity to a secure base overrides exploration in times of trauma or danger. Similarly, the anxiety of agoraphobia represents the terror of exploration away from the secure base. Further, stress activates attachment behaviour, even in circumstances where the source of the stress or anxiety is the attachment figure herself, resulting in the natural pull back to the secure base (Sable, 2004) (Holmes, 2006, p. 72).

Bowlby believed separation anxiety was a normal affective response to the absence of an attachment figure and when in the presence of danger (Gullestad, 2001). Separation protest can be seen in the therapeutic relationship when a client responds to an interruption in therapy, for example breaks in treatment, time between sessions or holiday breaks (Holmes, 2006, p. 72). This reaction is an expression of attachment behaviour and may present as anger, distance, distrust and feelings of

abandonment (Farber et al., 1995). Bowlby asserts that how a therapist evaluates these reactions will provide her with a deeper layer of understanding of their meaning (Bowlby, 1988, p. 173). These reactions provide opportune learning for the client who will benefit by exploring the contrast between their reactions of the new attachment figure (therapist) versus those of their original attachment figure (mother) (Farber et al., 1995).

Similar to Bowlby, Winnicott believed that anxiety and anger is reactive rather than instinctual. However, Bowlby believed it was in response to separation, Winnicott believed it was in response to a not good enough environment (Slochower, 2018). For Winnicott, one of the functions of a transitional object was to manage separation anxiety aroused by the absence, or anticipated absence of an attachment figure (Arthern & Madill, 2002). An individual will experience less separation anxiety if they have a sense of object constancy, the ability to evoke the image and 'felt sense' of a person in their absence (Arthern & Madill, 2002). This correlates to Bowlby's internal working model which Arthern and Madill (2002) state is essentially a schema of the attachment figure which can be activated when the attachment figure is absent. If a client has not developed object constancy, a holding environment may facilitate its development, and the therapist herself may become a transitional object in this process (Chescheir, 1985). The presence of a transitional object in the therapeutic relationship has been found to strengthen the relationship and is a sign of the client's maturity and psychological growth (Arthern & Madill, 2002).

Dependency

A common theme in Winnicottian and Bowlbian concepts is the importance of the client's dependence on the therapist. Meyer (1993) states that the therapist has "a better grasp of the patient's inner psychic reality than does the patient and therefore can help clarify what is bewildering and confusing". The therapist protects the client "from the dangers of the world" and "stands as a shield between the patient and these dangers". Contrary to Winnicott's concept of 'towards independence',

Clarkson (2003, p. 148) argues that the ‘overarching paradigm or archetype’ of the primacy of early relationship and the holding environment encourages a ‘manipulated dependency’ and a False Self through the powerful therapist and submissive, disempowered client in the relationship (Clarkson, 2003, p. 149). She further questions whether holding helps an individual develop resources, skills and competencies for dealing with real life.

Winnicott states “eventually the False Self hands over to the analyst” which “is a time of great dependence, and true risk, and the patient is naturally in a deeply regressed state” (Winnicott, 1956). Balint posits that not all regression leads to a ‘new beginning’ and that the client could get stuck in a regression rather than use it to further growth (Balint, 1969). Bowlby’s concept also supports the importance of dependence and its activation in adulthood and values it as an “intrinsic and valuable part of human nature” (Bowlby, 1988, p. 13). He refutes its activation in adulthood being regarded as regressive and terms this an ‘appalling misjudgement’ (Bowlby, 1988, p. 13).

Omnipotence, Omniscience and Mutuality

Both theories have been criticised for the presence of a superior, omniscient therapist as ‘all knowing’, ‘wiser and stronger’ and ‘better able to cope with the world’ (Farber et al., 1995). As the therapist facilitates the client’s regression through the protective holding space, early failures are relived and healed and the maturational process re-commences, revitalising the True Self (Slochower, 2013). This rather romantic notion of the therapeutic relationship was criticised by relational theorists who argued that a client was not a metaphorical baby, but an adult, far more knowing and complex than a baby (Slochower, 2013). They rejected the therapist as idealised mother and challenged her emotional superiority and objective removal from the therapeutic relationship, excluding her subjectivity (Slochower, 1996b). They refuted the omniscient, authoritarian, powerful therapist and helpless, unknowing, infantilised client (Aron, 1991).

The grandiose therapist and helpless, dependent client deprives the client of a complex, adult, conflictual way of experiencing and relating, restricting the experience to only the circumscribed, empathic, mothering therapist (Aron, 1991) (Slochower, 2018). This may result in a dependent relationship or the expectation that the therapist knows best (Farber et al., 1995). Further, Carveth (2013, p. 145) posits that another danger of offering a “kind of reparative re-parenting” is that it appeals to the therapist’s unresolved omnipotence. Parish & Eagle (2003) also found that clients were more likely to look up to their therapists than their primary attachment figures and proposed that therapeutic relationships are asymmetrical in nature – the therapist is sought out specifically for help because of their presumed expertise.

However, Winnicott emphasised the importance of the client’s dependence on the therapist’s maternal function (Slochower, 1996b). The cocoon-like experience of holding allows the client to experience omnipotence and self-sufficiency which gradually facilitates sufficient ego integration in order that the he may investigate his inner world (Modell, 1976). The therapeutic relationship then transitions from holding to collaborative mutuality where the therapist exposes her externality to the client through her failures and unreliability and also through exploration of enactments, transference and counter-transference within the relationship (Slochower, 1996b). Thus, the therapeutic relationship becomes a co-created, mutual experience – both therapist and client systematically affect, and are affected by one another (Aron, 1991). In circumstances where object usage is elusive and mutuality and inter-subjectivity may present a possible threat for the client, the suspension of the therapist’s subjectivity and use of a holding environment is an appropriate therapeutic alternative to preserve the illusion of the therapist’s attunement (Slochower, 1996b). Paradoxically, Slochower (1996b) proposes that it is ultimately the loss of the illusion of attunement that allows a truly mutual relationship.

Multiplicity, Monotropy and Self States

Winnicott's True and False Self clashed with relational theorists' ideas that self-states were fluid and undefinable (Slochower, 2018). They argued that it was not possible to locate a True or False Self because there is no fixed self and what is experienced shifts from moment to moment (Slochower, 2018). Muran and Safran (2000) posit that there is no "unitary, static true self waiting to be discovered", rather multiple self-states competing for awareness at any given time. Although people experience themselves as unitary and unchanging, there are many different self-states which become dominant at different times, particularly in a relational context (Safran & Muran, 2000, p. 67).

This correlates to Bowlbian theory of multiple internal working models for multiple relationships, despite his strong belief in monotropy and the primacy of the maternal relationship (Safran & Muran, 2000, p. 142). Harris (1999, p. 152) supports this theory and proposes that the characteristics an individual contributes to its relationships are what is significant. In essence, security or insecurity of the child does not reside in the child, rather in its relationships. The presence of multiple selves holds that there is no central executive control in ego formation, rather a self-organising psychic system which encompasses the wider external environment and its influences (Safran & Muran, 2000, p. 168). Further Waters et al. (2002) state that attachment theory is complicated by the fact that most adults maintain a number of close relationships which provide secure base functions in different contexts. Kegan (2009, p. 115) posits that the maternal role of holding can also be present in adult life in the wider societal environment. As Winnicott stated there is no such thing as "just an infant", there is also no such thing as "just an individual", without its environment (Winnicott, 1965). There is not just one formative environment in early life, rather a succession of psychosocial holding environments in which we are embedded in the cultures of, for example, school, peers, the physician and family (Gerretsen & Myers, 2008).

Safran and Muran (2000, p. 69) posit that an individual's experience of them self is entirely selective and based upon awareness in that particular moment, taking into consideration dissociation, repression, resistance and regulation. Further, the therapeutic relationship does not unify different

parts of the self, rather brings them into dialogue with one another through the client's increased awareness. Slochower (2018) nicely summarises:

“There's no simple baby –or adult – in the consulting room because both members of the dyad move from moment to moment, imperceptibly and unconsciously – toward and away from relating to the other as a collaborative subject. In this process, patient and analyst contact, enact and perhaps meet the needs of these baby and child self-states, for better and for worse.”

CONCLUSION

This paper sought to facilitate a greater understanding of the concepts of holding and secure base, their utilisation in practice and implications for the therapeutic relationship. Although both concepts are well articulated from a theoretical perspective, they perhaps lack more clinical direction. Further research could bridge the gap between these theories and their clinical application, clarifying the specific interventions used in therapy and illuminating how holding and a secure base influence the therapy process. In consideration of the power and omniscience of the therapist in these concepts, this paper also raised the question as to whether the resultant 'move to independence' or re-constructed internal working model is a learned behaviour or fundamentally reparative.

The maternal aspect of the therapeutic relationship is clearly complex and contentious. Relational patterns and attributes between mother and infant that facilitate psychic development in childhood will not necessarily have therapeutic value in adulthood. The application of a maternal metaphor in the therapeutic relationship in many ways blurs the lines of what constitutes therapy and caregiving and may over simplify the therapist's role. However, Bowlby and Winnicott's work has had an enormous impact on how we view intimate human relationships and has greatly enriched and deepened the understanding of the complexities of the therapeutic relationship. Despite their differences, Winnicott and Bowlby agreed on one thing – the innate need and formative nature of early relationship in psychic development and the reparative power that exists within the context of the mutual, empathic, maternal aspect of the therapeutic relationship. This paper ultimately highlighted the importance of mutuality in the therapeutic relationship; client and therapist engage in an ongoing relational dance that is co-created.

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