needs his mother's continuous and detailed study. For instance, she must not be anxious when holding him, etc. At first he does not know at all what she does or what she sacrifices for him. Especially he cannot allow for her hate. He is suspicious, refuses her good food, and makes her doubt herself, but eats well with his aunt. After an awful morning with him she goes out, and he smiles at a stranger, who says: "Isn't he sweet?" If she fails him at the start she knows he will pay her out for ever. He excites her but frustrates—she mustn't eat him or trade in sex with him.

["Hate in the Countertransference", p. 201]

This list could also apply to the psychotic patient in relation to the analyst.

I think that in the analysis of psychotics, and in the ultimate stages of the analysis, even of a normal person, the analyst must find himself in a position comparable to that of the mother of a newborn baby. When deeply regressed the patient cannot identify with the analyst or appreciate his point of view any more than the foetus or newly born infant can sympathize with the mother.

["Hate in the Countertransference", p. 202]

Nine years after this paper was written, in his paper, "Primary Maternal Preoccupation", Winnicott describes the mother just before giving birth and for a few weeks afterwards as being in a state of merger with her new-born infant. Although the theory of hate has not been linked with primary maternal preoccupation by Winnicott, the same themes are present in terms of what the analyst has to be able to tolerate from the regressed patient. It is the toleration of a ruthless love, and it is this ruthlessness that will instigate hate (see PRIMARY MATERNAL PREOCCUPATION; 4; REGRESSION; 12). These themes are also related to absolute dependence, the fear of WOMAN, and depression. (see DEPENDENCE; 1, 3; DEPRESSION)

REFERENCE

1947 Hate in the Countertransference [W6]
By the 1950s, Winnicott’s use of the good-enough mother-infant paradigm as a way of understanding what could be provided in the analytic relationship had become the foundation of his theory of holding, and his focus was on the psychological holding-the-baby-in-mind in combination with the physical feeding, bathing, and dressing:

... the infant is held by the mother, and only understands love that is expressed in physical terms, that is to say, by live, human holding. Here is absolute dependence, and environmental failure at this very early stage cannot be defended against, except by a hold-up of the developmental process, and by infantile psychosis... we are more concerned with the mother holding the baby than with the mother feeding the baby.

[“Group Influences and the Maladjusted Child”, 1955, pp. 147–148]

It is because of the good-enough holding that the infant is more likely to develop the capacity to integrate experience and develop a sense of “I AM” (Me).

No doubt the instinctual experiences contribute richly to the integration process, but there is also all the time the good-enough environment, someone holding the infant, and adapting well enough to changing needs. That someone cannot function except through the sort of love that is appropriate at this stage, love that carries a capacity for identification with the infant, and a feeling that adaptation to need is worth while. We say that the mother is devoted to her infant, temporarily but truly.

I suggest that this I AM moment is a raw moment; the new individual feels infinitely exposed. Only if someone has her arms round the infant at this time can the I AM moment be endured, or rather, perhaps, risked.

[“Group Influences”, p. 148]

This is the time of absolute dependence, to which Winnicott refers as the “holding phase”. Generally speaking he believed that it is best if there is one main carer at the beginning of the baby’s life, and in optimum circumstances this person should be the biological mother. However, Winnicott’s contention throughout his work is that an adoptive mother who is able to go into a state of primary maternal preoccupation will also be able to offer the necessary ingredients of the holding environment. (see Mother: 5).

Winnicott’s view of the good-enough holding environment begins with the mother-infant relationship within the family and grows outwards to other groups in society. In the preface to his collection of papers, The Family and Individual Development (W8), he emphasizes this point:

The family has a clearly defined position at the place where the developing child meets the forces that operate in society. The prototype of this interaction is to be found in the original infant-mother relationship in which, in an extremely complex way, the world represented by the mother is helping or hindering the inherited tendency of the infant to grow. It is this idea that is developed in the course of this collection of papers...


In 1960, Winnicott’s definitive statement on holding appears in his paper, “The Theory of the Parent-Infant Relationship”. The holding environment necessarily includes the father.

Satisfactory parental care can be classified roughly into three overlapping stages:

a. Holding.

b. Mother and infant living together. Here the father’s function (of dealing with the environment for the mother) is not known.

c. Father, mother, and infant, all three living together.

[“Parent-Infant Relationship”, p. 44]

“Living together” refers to the infant’s ability to separate Me from Not-me and to see mother and father as separate, whole people. This can occur only as a consequence of a successful holding by the parents and leads to an appreciation of reality and “to a three-dimensional or space relationship with time gradually added” (“Parent-Infant Relationship”, p. 44).

It is Winnicott’s contention in his theory of holding that good-enough holding by the environment is responsible for the initiation of certain developmental processes.
2 The holding function

The parents must provide their infant with an environment that is suited to his needs. It is of no use to the child if they offer him something that they themselves think he needs. This attitude may force the child to become compliant, because under pressure from the parent the child may say he likes something when he does not. Winnicott means that the parents must always take the infant’s integrity into account when providing for their child and respect him as a separate human being, which necessarily includes the right to be different.

Winnicott enumerates the necessary characteristics of the environmental provision.

It meets physiological needs. Here physiology and psychology have not yet become distinct, or are only in the process of doing so; and

It is reliable. But the environmental provision is not mechanically reliable. It is reliable in a way that implies the mother’s empathy.

Holding:

Protects from physiological insult.

Takes account of the infant’s skin sensitivity—touch, temperature, auditory sensitivity, visual sensitivity, sensitivity to falling (action of gravity) and of the infant’s lack of knowledge of the existence of anything other than the self.

It includes the whole routine of care throughout the day and night, and it is not the same with any two infants because it is part of the infant, and no two infants are alike.

Also it follows the minute day-to-day changes belonging to the infant’s growth and development, both physical and psychological.

[Winner: Infant Relationship", pp. 48-49]

Winnicott stresses that the quality of maternal care at the very beginning of life is responsible for the mental health of the individual in terms of freedom from psychosis.

Transposed to the therapeutic relationship, it is the setting in analysis that provides the necessary holding environment for the patient (see Environment: 2). (The analytic setting = a holding environment.)

3 Personalization

Part and parcel of holding is what Winnicott refers to as handling—the way the mother handles her infant in all the day-to-day details of maternal care. Here is included a mother’s enjoyment of her baby, which is an expression of her love. (See Mother: 9)

Good-enough handling results in the infant’s “psyche indwelling in the soma”; Winnicott refers to this as “personalisation”. This means that the infant comes to feel, as a consequence of loving handling, that his body is himself or/and that his sense of self is centred inside his body. (See Psych/Soma: 1)

Winnicott uses the term “personalization” to accentuate the opposite of “depersonalization”—the condition in which the individual experiences a mind-body split and does not feel himself inside his body:

Being loved at the beginning means being accepted ... the child has a blueprint for normality which is largely a matter of the shape and functioning of his or her own body.

Almost every child has been accepted in the last stages before birth, but love is shown in terms of the physical care which is usually adequate when it is a matter of the fetus in the womb. In these terms, the basis for what I call personalisation, or an absence of a special liability to depersonalisation, starts even before the child’s birth, and is certainly very much a matter of significance once the child has to be held by people whose emotional involvement needs to be taken into account, as well as their physiological response. The beginning of that part of the baby’s development which I am calling personalisation, or which can be described as an indwelling of the psyche in the soma, is to be found in the mother’s ability to join up her emotional involvement, which originally is physical and physiological.


In the analytic situation, it is the analyst’s attention—in combination with the physicality of the environment, the couch, the warmth, the colour of the room, and so on—that mirrors the mother’s primary maternal preoccupation. Winnicott’s concept of holding in the therapeutic setting does not include the analyst touching the patient. (See Communication: 3; Hate: 4; Regression: 1)
Management

Winnicott often referred to holding as a form of management—especially when he was addressing groups of professionals who were involved in the daily care of people who could not care for themselves. Management was also the term used for the care of patients in a psychiatric setting, as well as in the analytic relationship. The degree of management depends on the pathology of the patient in terms of how much holding is required:

In treatment of schizoid persons the analyst needs to know all about the interpretations that might be made on the material presented, but he must be able to refrain from being sidetracked into doing this work that is inappropriate because the main need is for an unclerical ego-support, or a holding. This "holding", like the task of the mother in infant-care, acknowledges tacitly the tendency of the patient to disintegrate, to cease to exist, to fall forever.

["Psychiatric Disorder in Terms of Infantile Maturational Processes", 1963, p. 241]

Winnicott stresses the importance of management as a holding environment for the treatment of children and adolescents who are demonstrating an antisocial tendency. However, he was aware of how much holding the staff also required in order to work with individuals who made such heavy emotional demands on the carers. A paper written with Clare Britton in 1947, "Residential Management as Treatment for Difficult Children", details all the aspects of residential care in relation to the crucial aspects of a holding environment. Its conclusions are relevant to this day.

In terms of the analytic relationship it is the setting, the analyst's attention, along with and including the interpretative work that creates the holding environment that manages the patient's psychological and physical needs. Only from this holding can a potential space be realized (see TRANSITIONAL PHENOMENA: 7). (The consequences of the failure of the holding environment are explored in ENVIRONMENT: 3, 4, 5, 6.)

REFERENCES

1955 Group Influences and the Maladjusted Child [W8]
1960 The Theory of the Parent-Infant Relationship [W9]
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1965 The Family and Individual Development [W8]
1970 On the Basis for Self in Body [W19]