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# Holding, attaching and relating : a theoretical perspective on good enough therapy through analysis of Winnicott's good enough mother, using Bowlby's attachment theory and relational theory

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Lydia Borg  
Holding, Attaching and Relating: A  
Theoretical Perspective on Good  
Enough Therapy through Analysis of  
Winnicott's Good Enough Mother,  
using Bowlby's Attachment Theory  
and Relational Theory

### **ABSTRACT**

This is a theoretical study in which Winnicott's ideas on the "good enough mother" are analyzed in search of implications for what makes a good enough therapist. Specifically these ideas are explored through the lenses of attachment theory and relational theory with a focus on the work of John Bowlby and Jessica Benjamin respectively. Particular attention is given to the roles of both therapists and mothers in "holding", emotional regulation, protection, and building emotionally facilitative and protective relationships. This paper includes in depth looks at these theories and the ways in which the concepts within attachment theory and relational theory (specifically the ideas of attachment relationships, subjectivity and intersubjectivity) both echo and expand upon Winnicott's work. This paper posits that the primary similarity found in all three theoretical standpoints is the significance of human connection and relationship in healthy emotional functioning. Additionally, the argument is made that the three theories are complementary to one another, and a more comprehensive understanding of individual development and psychology is gained from application of them in conjunction with one another, as opposed to applying the theories individually. The concepts discussed throughout the paper are explored via a case example in the final chapter.

**HOLDING, ATTACHING AND RELATING: A THEORETICAL PERSPECTIVE ON  
GOOD ENOUGH THERAPY THROUGH ANALYSIS OF WINNICOTT'S GOOD  
ENOUGH MOTHER, USING BOWLBY'S ATTACHMENT THEORY AND  
RELATIONAL THEORY**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2013

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## **CHAPTER I**

### **Introduction**

Throughout the history of the psychological study of humans and human behavior, the role of the mother has been central across many theories. Mothering has been defined as essential to fostering child development both physically and emotionally; thereby cementing the importance of mothering in nurturing psychological well-being in generations of healthy adults. As psychoanalytic and psychotherapeutic theories have developed there continues to be emphasis on the maternal role, and the maternal aspects of the therapeutic relationship. This paper examines the maternal role of the therapeutic relationship in the context of Winnicott's ideas on the "good enough mother" which is later analyzed through the lenses of attachment theory and relational theory respectively. This writer uses attachment and relational theories to further illuminate the phenomenon of "therapist as mother", to explore how this phenomenon does or does not function within those theories, and to explore what a "good enough" therapy is. The work of John Bowlby is the focus of discussions of attachment theory, and the work of Stephen Mitchell, Lew Aron, and Jessica Benjamin inform discussion of relational theory. Attachment theory offers a perspective that centrally values relationship while taking a somewhat biological approach, whereas relational theory offers a more complex, "two-person" approach, which holds subjectivity and intersubjectivity as focal points for analysis.

Examining the parallels between mothering and therapy within these theoretical frameworks is an attempt at further illuminating the workings of the therapeutic relationship. In

the current psychological literature, strength of the therapeutic alliance is often emphasized as significant in predicting outcomes of therapy. In a climate where therapeutic alliance and relationship are losing clout due to contemporary psychotherapeutic treatment becoming increasingly shorter in length and more cognitively and behaviorally based (with DSM diagnosis and symptomology often taking precedence in the treatment) a careful theoretical examination of the therapeutic relationship and the maternal functions it fulfills is an opportunity to revisit and discover more about the relationship that is almost universally accepted by the psychological community as one of great importance.

In this paper the argument is made that Winnicottian, attachment, and relational theories hold in common the significance of relationship and connection in healthy emotional functioning. Additionally the theories discussed are found to be complementary to one another and more comprehensive when combined as opposed to being used separately for analysis. A case example in the final chapter serves to illustrate this point.

The following chapters will undertake exploration of maternal function in the therapeutic relationship as described above. In the next chapter, the reader is introduced to the conceptualization and methodology of the project in greater depth.

## **CHAPTER II**

### **Methodology and Conceptualization**

As indicated in the introduction, the two theories used in this analysis will be attachment theory and relational theory. They will be examined in relation to Winnicott's ideas on child development respectively. The reader will first be introduced to Winnicott's theories on child development, specifically using concepts including the holding environment, emotional integration, and the role of the good enough mother. These concepts will then be discussed in terms of their relation and similarities to the dynamics and purpose of the therapeutic dyad, illuminating the comparisons between mothering and therapy. Detailed explanation of these ideas using Winnicott's writings will constitute the bulk of the initial chapter. Wilfred Bion's conceptualizations of the container/contained and metabolization of beta-elements into alpha elements will also supplement Winnicott's ideas in the explanation of the maternal metaphor. Once an understanding of the phenomenon of therapist as mother has been determined, I apply this phenomenon to other psychological theories in hopes of finding out what good enough therapy, or a good enough therapist is.

Moving forward the reader will then be given an introduction to attachment theory primarily using John Bowlby's theories on attachment. Specifically the importance of security and stability of attachment, along with the role of attachment in emotional regulation will be discussed. These concepts will then be compared and contrasted to Winnicott's thoughts on dependence, a good enough holding environment, and emotion integration. Finally the



exploration of attachment theory will address the questions: What purposes do mothers and therapists/therapy serve through the lens of attachment theory? And, what is a good enough therapist/mother through the eyes of attachment theory?

The next chapter will be a comparable analysis of relational theory including an introduction to the theory, examination of its core theoretical concepts and questioning the role of the mother and therapist through a relational lens. Examination of the centrality of the relationship, subjectivity, intersubjectivity, and the idea of the “two-person” therapy will be of importance in the analysis. Specifically the theories of Stephen Mitchell, Lew Aron, and Jessica Benjamin will be prominent in this conceptualization of relational theory. Central to the analysis is a comparison of Winnicott’s concepts and how they fit into relational theory. Similar to the consideration given to attachment theory, this information will be used to determine what a “good enough” therapy is in relational theory.

The paper concludes with a discussion of the findings of the above analysis. The theories are compared and contrasted in order to determine what can be contributed to clinical understanding from each and where there are limitations and shortcomings in them. Case material is used to help ground the reader in the concepts and illuminate the presence of the maternal metaphor within the therapeutic dyad. Consideration of the cultural influences behind theory are noted, along with contemplation about how these concepts may or may not fit into contemporary practice and understanding. Finally the discussion will review the contributions of these theories to the understanding of the maternal metaphor within therapy both individually and in combination with one another.

## **Considerations of Bias, Strengths, Limitations and Intended Outcomes**

As with any research being undertaken, one must examine the biases present within the researcher and within the research material. Within the theories examined there will undoubtedly be the biases and opinions of the theorists. At the outset of the research I recognize that, by its nature, theoretical material is subjective rather than objective. In approaching this topic it will be useful to look at the concepts themselves as they apply (or do not apply) to contemporary understandings as opposed to a strictly literal translation of the original writings. Obviously culture and accepted psychological thought have changed over time, and some of the material included in this analysis was written half a century ago. It is my intent to search for the quality and usefulness of the content to analyze it in a meaningful way as opposed to attempting to justify outdated material that has little relevance to contemporary understandings. Outstanding instances of bias will be addressed directly in discussion of each theory as applicable.

The topic of mothering itself, an idea central to this research, is open to cultural, societal, and individual interpretation as well. The idea of mothering, especially when considering the therapeutic relationship, is subjective in many ways. One person may believe that there is maternal overtone to the therapeutic relationship whereas another will not perceive it. Unfortunately that is the nature of the subject and it cannot be avoided. In considering this project it is important to recognize that the ideas of “good enough mother” that compose the focus of this project come specifically from a white British male from the middle of the 20<sup>th</sup> century and therefore will reflect his personal and cultural biases. This will be addressed in the discussion section of the paper. Sandbank (1993) noted, “the analyst’s approach...is very much connected to his own inner experience of being a child, of being parented” (p. 15). Similarly, I as the researcher and developing therapist, have my own personal experiences, cultural background,

societal background, beliefs, and values that inform my understanding of both mothering and therapy. Despite these experiences that affect my understandings it is my intent to let the theoretical material in this project speak for itself as much as possible.

### **Strengths and Limitations**

The phenomenon to be discussed, the idea of therapist as mother, is quite a broad topic. This can be seen as both a strength and a weakness of the proposed project. Because it is a broad topic, which several theorists have written about, there is room to explore the phenomenon through many differing theoretical lenses. Its breadth also gives it the benefit of being applicable to several theories, and clinical situations. On the other hand, exploration of such a broad topic also brings limitations. There is a wealth of knowledge and literature on the topic and not everything can be covered within the scope of this project. Literature on the topic will continue to expand after completion of this project and therefore the findings of the project will only be relevant as long as they fit into current theoretical understandings. Because they are theories and not objective truths, this research will not provide answers or facts but instead will give new perspectives and hopefully encourage thought in regards to the phenomenon and the theories addressed. The findings of this project will be limited to the theories covered in the research.

### **Intended Outcomes**

Despite limitations, possible findings of the project will include new ways to understand the therapeutic relationship. Ideally the findings will provide implications for practice within attachment theory and relational theory specifically in regards to the phenomenon of therapist as mother. It is the hope of this researcher that implications for clinical work, specifically looking at what “good enough” therapy means, will come as a result of this work.

## **CHAPTER III**

### **Winnicott and the Good Enough Mother**

#### **Winnicott: A Brief History and Background**

Donald Winnicott was a British pediatrician and psychoanalyst. He was born in 1896, forty years after Freud, and in the midst of the growth of psychoanalysis as a legitimate field. Winnicott studied biology at Cambridge University and then attended medical school. Following completion of medical school he received three appointments to work with children in hospitals and within the same year started a private practice of children's medicine (Rodman, 2003). Unbeknownst to him, Winnicott's background in children's medicine would go on to inform his attentive observations of children and in turn his theories about child development and psychology; observations which later led to his recognition as "one of the most original of psychological and philosophical thinkers" and "...a clinician of extraordinary skill" (Rodman, 2003, p.5). Though others find him noteworthy Winnicott himself had a casual take on his process of development of theory; addressing the crowd during a presentation in 1945 he explained his academic process: "What happens is that I gather this and that, here and there, settle down to clinical experience, form my own theories and then, last of all, interest myself in looking to see where I stole what" (Rodman, 2003, p.3).

During his career there were ongoing internal struggles in the psychoanalytic community over who was developing theory in true Freudian tradition. Winnicott studied under Melanie

Klein and contributes much of his initial knowledge of child analysis to her supervision and guidance (Winnicott, 1965). Though he studied under Melanie Klein he later stated that his own views separated from hers and he admitted he could never, “follow anyone else, not even Freud” (Winnicott, 1965, p. 177); he was a pioneer in his field. Perhaps this fierce independence in combination with his focus on clinical experience in the development of his own theories are what keep his thinking relevant and important to psychoanalysis today.

### **Winnicott on Child Development and the Role of Maternal Care**

To draw the comparison between Winnicott’s “good enough mother” and the psychotherapeutic relationship we must first understand Winnicott’s theories. At the root of his theories is a belief in a natural “inherited tendency toward development” (Winnicott, 2002, p. 179). In contrast to the Freudian idea of sexual and aggressive drives motivating human behavior, Winnicott’s ideas have an organic feel to them; he believed that babies, if provided the right environment (physically and emotionally) will develop naturally, and mothers in most cases naturally know how to provide appropriate nurturing conditions. He believed that children inherently reach toward an independent existence (Winnicott, 1960). In contrast to traditional Freudian views that covered the roles of internal structures, Winnicott took into consideration the human as a whole. His view of human development is not based solely on internal structures but is rather based upon the interaction of the baby’s innate qualities and the quality and consistency of maternal care he is provided. His writings imply an instinctual quality of the way in which babies progress developmentally and of their mothers knowing how to facilitate a child’s physical and emotional development.

Central to Winnicott’s theories is that the child is in a state of complete dependence upon the caregiver in early life. He believed that this absolute dependence in the beginning was

healthy and normal. He famously emphasized the degree of dependence he believed infants to have with the controversial assertion that, “there is no such thing as a baby” (Winnicott, 1964, p.88) He later clarified this statement saying, “if you set out to describe a baby, you will find you are describing a *baby and someone*. A baby cannot exist alone but is essentially part of a relationship” (Winnicott, 1964, p. 88). He conceptualized the infant and maternal care as one unit, as two entities that “cannot be disentangled” (Winnicott, 1960, p. 586). He saw that as an adult, the mother has capacity for independence whereas the infant’s helpless membership in this duo leaves him absolutely dependent (Winnicott, 1960). Winnicott recognized that “absolute dependence” was not permanent and conceptualized “relative dependence” and “towards independence” as the developmental stages subsequent to the initial state (Winnicott, 1960). Progression through these stages begins in a state where the infant is oblivious to the maternal care being provided and is powerless to his environment. In relative dependence the infant identifies that maternal care exists and begins to relate it to his needs and impulses. In the final stages moving toward independence, though the infant still does not have control over his environment, he is able to soothe himself and feel secure using memories and introjections of his mother’s care, and the trust he now has in his environment (Winnicott, 1960). Developmentally the ability to soothe oneself via introjections from the mother coincides with the growing intellectual capacity of the child. Without the simultaneous development of intellectual capacity the child would be unable to utilize this process of introjection (Winnicott, 1960). The mother’s role in fostering independence as the infant reaches maturity will be discussed in the coming paragraphs. What is important to gather from Winnicott’s views on dependence are the following: first, dependence is a natural state that, if provided sufficient care, a child will

progress through. And second, a mother's task in providing physical care and maintenance is only the tip of the iceberg in the child's developmental process.

Winnicott formed many concepts that he used to describe the mother/child pair and their development. As discussed above, he believed it was healthy for a baby to have its physical and emotional needs met consistently by a caregiver, a task he thought to be especially important in the extreme dependent phase of infancy. Winnicott believed that a caregiver's own needs would eventually temporarily distract her from those of the baby and inevitably interrupt the baby's initial state of "going on being". Consequently, as the child ages and the mother fails to anticipate his every need the infant will ultimately be disappointed in some way, some emotional or physical needs will go unmet, and he will realize that there are other beings, actions, motives, that are "not me". He believed that eventually, via these misattunements between mother and child, times when the mother could not either anticipate or meet the immediate needs of the child, the child would begin to gain independence. At the right age Winnicott saw the realization that there is something that is "not me" as a healthy step toward independence. Though he felt slight misattunements were to be expected between mother and child, he warned against the detrimental psychological effects that could occur if mothers too often did not foresee and meet these needs, and the realization of "not me" came too early for the child.

In order to so consistently meet the needs of their babies, Winnicott postulated that mothers have a unique ability to put all of their focus and energy on their child: he referred to this phenomenon as the "primary maternal occupation". The primary maternal occupation, he believed, is what allows new mothers to focus so intently on their infants needs that they may disregard or even completely forget their own. He spoke of the primary maternal occupation as follows:

It is a special thesis of mine that mothers, unless they are psychiatrically ill, do orientate to their very specialized task during the last months of pregnancy, and that they gradually recover from this in the course of weeks and months after the birth process...In this state, mothers become able to put themselves into the infant's shoes, so to speak. That is to say, they develop an amazing capacity for identification with the baby, and this makes them able to meet the basic needs of the infant in a way that no machine can imitate, and no teaching can reach. (Winnicott, 2002, p. 33)

He emphasized that the primary maternal occupation is both a human ability, and a temporary one; a natural state that women undergo beginning in pregnancy and which they experience throughout the infancy of their child. Though many people can imagine what an infant is experiencing, Winnicott attributed a heightened ability to mothers, one that goes beyond the normal ability. Emphasizing the complexity of the mother's caretaking tasks he said, "I am not simply referring to her being able to know whether the baby is or is not hungry, and all that sort of thing; I am referring to innumerable subtle things" (Winnicott, 2002, p.13).

The primary maternal occupation is seen to help in the creation of what Winnicott called, a "holding environment". Winnicott's understanding of "holding" goes beyond the physical act of holding a child to include aspects of emotional regulation. Further clarifying the extension of the term beyond the physical definition he said that holding was "the total environmental provision" and that it includes "management of experiences that are inherent in existence" (Winnicott, 1960 p. 589). Referring to the period of the primary maternal occupation Winnicott said, "I am contented to use the word hold, and to extend its meaning to cover all that a mother is and does at this time...where she acts naturally *naturally*. It is here that she cannot learn from books" (Winnicott, 2002, pg. 13). The above description is both extensive and vague; by his



standards holding means “all that a mother is and does”. He conceptualized holding as something that occurs constantly while the child is “merged” with the mother; specifically, all that is done for and with the child before the child develops some capacity to have object relationships as opposed to existing in a singular unit with his mother (Winnicott, 1960). Theoretically satisfactory holding is of great importance developmentally to Winnicott as evidenced by the following: “In an environment that holds the baby well enough, the baby is able to make *personal development according to inherited tendencies*” (Winnicott, 1986, p.28); the inference can be made then that without sufficient holding, the child would not be able to develop to its innate potential. He believed that there are many crucial aspects of holding and more generally of maternal care which are of great importance. Maternal care and holding reliably meet physiological needs and protect from physiological insult “throughout the day and night” all while taking into account heightened (on many levels) sensitivity of the infant. (Winnicott, 1960, p. 592). More simply put he believed that holding “is a form of loving” (Winnicott, 1960, p. 592).

Winnicott believed that a sufficient holding environment and maternal care helped children accomplish emotional integration in early childhood. He observed that in infancy good and bad things happen constantly and they are all out of the infant’s control. Winnicott believed that it is maternal care, specifically the ego support that the mother provides to the child, that enables the child to live and to develop despite his lack of control over the environment (Winnicott, 1960). According to Winnicott, the infant has no control over the environment. However, in the case of an infant being provided a good enough holding environment and therefore having his needs met, the infant is unaware of his lack of control over the environment; the experience of the infant is paradoxically, one of control or in Winnicottian terminology,

“omnipotence” (Winnicott, 1960). Winnicott spoke of the way a baby would, knowing no other state than having its needs met continuously, be able to “continue going on being”. He based the idea of “going on being” on the notion that as a result of having needs met constantly, omnipotence is not interrupted. Infants are unaware that their desires (hunger, need for soothing, grasping for an object) are anticipated and facilitated by another and therefore initially do not question the power they believe themselves to have; the power that brings their mother’s breast to them when they are hungry and soothes them when they are upset. Based on the all-encompassing strength of their perceived connection to the outside world Winnicott believed infants did not have a sense of what is “not me”. Starting from their growth in the womb and continuing into the first months of life he hypothesized that babies have little idea that there is anything in the world that is “not me”; their experience is centered on themselves without awareness that an “other” exists.

Though initially complete dependence is seen as essential and normal, eventually the infant progresses toward a more independent state leaving behind their ability to continue “going on being” and replacing it with a more informed understanding of their relationship to the world where they recognize they have much less power than initially thought. Winnicott saw infancy as a time of ego development where emotional “integration” was the key developmental task of the child. Freud’s pre-existing notions of the id and the ego informed Winnicott’s thinking. Using Freud’s understanding of the id as uncontrolled desires, Winnicott, in keeping with the belief that infants do not have control of their surroundings, postulated that initially infants experienced id impulses as external to themselves; infant desires, including something as simple as a desire for food, is not recognized by the infant as coming from himself but is contrarily external and frightening. Winnicott’s “integration” then is the task of integrating id impulses into control of

the ego thereby strengthening the ego; helping the infant to identify and emotionally survive or manage internal impulses leads to the development of an ego (Winnicott, 1960). In other words the state of going on being is interrupted and the infant begins to make basic sense of what is going on around him. During the holding phase “the ego changes over from an unintegrated state to a structured integration” and simultaneously gains “a linkage of motor and sensory and functional experiences”- a physiological identification of the limits of one’s self that coincides with the inklings the child is having of the existence of a “not me” (Winnicott, 1960, p. 589). In his opinion maternal care, especially in the form of ego support, is “the main reason” a child’s ego develops healthily (Winnicott, 1960). Concurrent with ego development and an increasing sense of self, the emergence of the mind as separate from the psyche leads to a child’s naïve capacity for object relations.

The mother’s capacity to engage in a primary maternal occupation, to provide a safe holding environment, to carefully facilitate a dependent state of “going on being” to a more independent recognition of the possibility of “not me” existing, and to make possible the integration of emotions from external experience to those which can be better managed through internal control, largely comprised what Winnicott considered to be “the good enough mother”. Though this collection of responsibilities and terminology may seem daunting and complicated, Winnicott insisted that these tasks came instinctually and even easily to most women. He referred often to the “ordinary devoted mother” and declared that with the exceptions of mothers who were either deceased, suffering from mental illness, or had another baby who took away some devotion from the first child at an early age, most children received “good enough” care (Winnicott, 1987). By “ordinary” he meant that “you do not have to be clever, you do not even have to think if you do not want to...it hasn’t anything to do with whether you are a good mother

or not” (Winnicott, 1964, p.16) and, he matter-of-factly pointed out, “by devoted I simply mean devoted” (Winnicott, 2002, p. 12). He reiterated the human qualities of maternal care often pointing out in his writings that machines could not accomplish the work of mothers. The following quotes detail his belief that “good enough” mothers are human and imperfect: “A good-enough mother starts off with a high degree of adaptation to the baby’s needs. That is what ‘good-enough’ means, this tremendous capacity that mothers ordinarily have to give themselves over to identification with the baby” (2002, p. 234) and,

anybody who reaches stable adulthood could not have done it if somebody at the beginning had not taken him or her through the early stages....The sort of thing I have been talking about could not be done by a computer- it must be *human* reliability (that is, unreliability really). (2002, p. 235)

Finally,

Of children, even of babies, it can be said that they do not do well on mechanical perfection. They need human beings around them who both succeed and fail. I like to use the words “good enough”. Good enough parents can be used by babies and young children, and good enough means you and me. In order to be consistent, and so to be predictable for our children, we must be *ourselves*. (2002 p. 179)

Interestingly it is the paradox of the mother’s ability to be both wholly dedicated to her child and to be humanly unreliable which defines “good enough” parenting. In fact, the imperfection of human care is what Winnicott valued as essential to fostering independence: “This is where the difference comes in between mechanical perfection and human love. Human beings fail and fail; and in the course of ordinary care a mother is all the time mending her failures” (2002, p.76). By providing for the child physically and emotionally but also disappointing the child at times the

good enough mother provides a balance which both satisfies the child and forces him toward independence.

Winnicott asserted that a good enough mother who provided good enough holding for her child was setting the child up for intact mental health. Though the mother may not be considering this specifically as part of her maternal task, Winnicott asserts that she will work toward this end naturally. He explains this concept with the following statement:

From my point of view the mental health of the individual is being laid down from the very beginning by the mother who provides what I have called a facilitation environment, that is to say one in which the infants natural growth processes and interactions with the environment can evolve according to the inherited pattern of the individual. The mother is (without knowing it) laying down the foundations of mental health of the individual. But not only that. If we assume mental health, the mother (if she is doing well) is laying down the foundations of the individual's strength of character and richness of personality. (Winnicott, 2002, p. 25)

Though he vehemently believed that most children received good enough care he also detailed the detrimental effects should a child not receive satisfactory care, especially during the initial period of absolute dependence. Again, he clarifies the connection he saw between maternal provision and mental health with the following:

A certain proportion of babies have experienced environmental failure while dependence was a fact, and then, in varying degrees, there is damage done, damage that can be difficult to repair. At best the baby growing into a child and an adult carries round a buried memory of a disaster that happened to the self, and much time and energy are spent in organizing life so that such pain may not be experienced again. At worst the

child's development as a person is permanently distorted so that the personality is deformed or the character warped. There are symptoms that are probably thought of as naughty, and the child must suffer from those who feel that punishment or corrective training can cure what is really a deep-seated fact of environmental failure. Or the child as a person is so disturbed that mental illness is diagnosed, and treatment is given because of an abnormality that ought to have been prevented. (Winnicott, 2002, p. 68)

From these words we can deduce his meanings; provision of good enough holding is highly significant for psychological well being in the future of the child.

### **The Maternal Metaphor: Therapy as Mothering, and Therapists as Mothers, with a Focus on Winnicottian Thought**

In order to compare therapy and mothering it is important to also understand how Winnicott viewed therapy. In a letter to his sister Violet dated November 5, 1919, Winnicott, just a few years prior to beginning his work in hospitals and with children, defines psychoanalysis as a method by which, simply by making one back step after another the patient is led to trace back his dreams and obsessions to their origin which has often been harboured since infancy or childhood. The patient is amazed to find his curious behavior explained and the cause brought up into consciousness. He is then able to bring his own will into the battle and his will is given a fair chance. (Rodman, 2003, p. 41-43)

Important to note is his view that psychoanalysis inherently involves consideration of emotional events from childhood or even infancy. Though Winnicott drew distinction between the three, this analysis will use “therapy”, “psychotherapy”, and “psychoanalysis” interchangeably.

At this point, given a basic understanding of Winnicott's concepts of child development, I will turn to discussion of the parallels between motherhood and therapy. Winnicott drew these

comparisons directly and, as you will see in the following paragraphs, the maternal metaphor in therapy is quite extensive.

To understand Winnicott's direct comparison of mothering and therapy, we begin with the following quote:

In treating mental ill-health we necessarily come across the details of early failures of facilitation. We meet the failures, but (remember!) the successes appear in terms of the personal growth that successful environmental provision made possible. For what the mother does when she does well enough is to facilitate the baby's own developmental processes, making it possible for the baby to some extent to realize inherited potential. All we do in successful psychoanalysis is to unhitch developmental hold-ups, and to release developmental processes and the inherited tendencies of the individual patient. In a peculiar way we can actually alter the patient's past, so that a patient whose maternal environment was not good enough can change into a person who has had a good enough facilitating environment, and who personal growth has therefore been able to take place, though late. When this happens the analyst gets a reward that is far removed from gratitude, and is very much like that which a parent gets when a child achieves autonomy. In the context of good-enough holding and handling the new individual now comes to realize some of his or her potential. Somehow we have silently communicated reliability and the patient has responded with the growth that might have taken place in the very early stages in the context of human care. (Winnicott, 2002, p. 78-79)

This quote is rich with important comparisons between therapy and the tasks of motherhood. First, Winnicott asserts that early maternal failures in facilitating a child's needs are reason for ill mental health. Second, he points out that therapists work to "unhitch developmental hold-ups,

and to release developmental processes and the inherited tendencies of the individual patient”.

Within these two assertions there are several implied connections between therapists and mothers. First, both therapists and mothers have been tasked with facilitating mental health; it is the job of a mother to facilitate successful mental health of a child, and similarly it is the job of a therapist to facilitate mental health, specifically by addressing the lapses of the mother in doing so initially. Both therapists and mothers can communicate reliability to the patient/child, which facilitates growth. Both are working toward helping an individual reach his inherited potential.

This quote also asserts that both mothers and therapists have the ability to provide a good enough holding environment which is beneficial to the child or patient. Additionally he makes the statement that, similar to a mother who looks forward to the independence of her child, a therapist who helps to facilitate independence of a patient receives some sort of “reward”.

Taking these similarities into consideration, it is no wonder that the common notion that therapists must “only do better than their patient’s parents” is in frequent circulation within the field of mental health.

Winnicott credited his theories to his observations of mothers and children but also his clinical work with both child and adult patients stating that, “they all become babies and children in the course of treatment” (2002, p. 236). This work taught him much about the role of the therapist in treatment. He said that the role of the therapist was to maintain the “image of the parent-figure” (2002, p.236); where a mother may have failed in providing reliability to her dependent child, it was a therapist’s duty to correct emotional disappointments via unwavering dependability.



## **Provision of Holding and a Holding Environment**

The idea of the holding environment provides one of the most prominent opportunities for parallels between motherhood and therapy. The metaphor of holding can be viewed from several perspectives. The following section will explore the several ways in which therapy can “hold” a patient.

The first way in which therapy and the therapist hold the patient is physically. Granted, physical touch is discouraged and even forbidden in some cases within the clinical dyad (National Association of Social Workers [NASW], 2008, American Psychological Association [APA], 2012), however there are other ways in which therapy provides holding to the patient. In modern psychotherapy it is standard for a patient to meet with a therapist in his or her office. With the exception of phone calls in between sessions the therapy is generally contained within the physical space of the therapist’s office. The therapist’s office is often kept organized and generally goes unchanged over time; though practical, this also serves the function of conveying reliability, stability, and safety which are inherent in the concept of holding. Though subtle, this is a factor that is in fact important, so much so that beginning clinicians are encouraged to pay attention to the privacy and environment created by their office, its setup, and décor (Sommers-Flanagan & Sommers-Flanagan, 2009). In this way, the therapist’s office physically contains the patient much in the way a mother might hold or contain an infant physically.

Within this metaphor the confidentiality of therapy acts as another means by which safety and a sense of holding is extended. Confidentiality is essential to the functioning of therapy or analysis; in therapy often a patient is expressing thoughts and emotions that he or she does not share outside of therapy. For this reason, and to give assurance that a patient’s most personal expressions will not be exposed, confidentiality is built into the ethics and standards governing

both social work and psychology on the national level and also into legislation affecting clinical practice (NASW, 2008, APA, 2012, & Health Insurance Portability and Accountability Act [HIPAA] 2003). Much like the physical space provides safety and reliability, confidentiality provides emotional safety and reliability. As a child may feel safe in his mother's arms, a patient may feel the safety of knowing that his innermost thoughts and feelings are held safely in the therapy room and solely with the therapist. In quite a literal way confidentiality ensures that a patient's shared emotional content is contained.

Remarkably, the demands present in the systems that provide therapy (many of them non-profit organizations or medical settings) constantly challenge the practical ability of clinicians to be reliable for their patients (Dwyer, 2006). In the face of unrelenting understaffing, underfunding, increasing caseloads and the pressure for "fast results" (Dwyer, 2006, p. 83) social workers and therapists rise to the challenge of creating reliability for patients. Though it can be safely assumed that many clinicians are driven by personal motivation and values, the ethics stated by the American Psychological Association, the National Association of Social Workers, and the British Association of Social Workers all reflect values which support Winnicott's sense of providing reliability as essential to facilitating mental health (APA, 2012, NASW, 2008, British Association of Social Workers [BASW], 2012). Across these organizations central values include being trustworthy, being accountable, maintaining competence, and assurance against early termination of or interruption of services; unquestionably these form the foundation for consistent and reliable provision of service which contributes greatly to the sense of holding present in therapy. A specific example that illustrates a Winnicottian recognition of the importance continued care is the following, which is found in the NASW code of ethics: "Social

workers should take reasonable steps to avoid abandoning clients who are still in need of services.” (NASW, 2008)

Though physical space, confidentiality, and ethical reliability are fundamental to Winnicott’s concept of holding and provide it to an extent, Winnicott postulated that insightful interpretations made in therapy could provide holding as well. He said,

A correct and well-timed interpretation in an analytic treatment gives a sense of being held physically that is more real ... than if a real holding or nursing had taken place.

Understanding goes deeper and by understanding, shown by the use of language, the analyst holds physically in the past, that is, at the time of the needs to be held, when love mean physical care and adaptation. (Winnicott 1988, p.61- 62)

He believed that accurate emotional alignment with a patient and subsequent interpretation that comes from it could provide holding in the same manner that mothers are able to predict and meet their child’s emotional needs. Taking at face value his earlier explanation of therapy as a means by which therapists work at correcting developmental “hold-ups”, it seems that interpretation is the tool he chose to accomplish this task.

Parallels can be drawn between the tasks of the therapist in relation to her patients and the primary maternal occupation as well. As the mother prepares for the birth and caretaking of her child, so a therapist prepares for her time with a patient. Mothers read parenting books, consult with other mothers, and take courses in preparation for the arrival of their child, and the therapist goes through schooling and ongoing training helping to familiarize herself with the requirements of the job and attain the skills to perform needed therapeutic tasks. Prior to the patient’s arrival to the office a prepared therapist will review the patient’s file and notes on their previous interactions getting her in the mindset of focusing fully on the patient. Once the patient arrives to

work with the therapist, the patient has the therapist's undivided attention. As the mother in the midst of primary maternal occupation instinctively takes time away from her other responsibilities to focus on the child, the time set aside for the patient is sacred, the therapist's personal needs are temporarily disregarded in favor of being fully present with the patient. As noted in Mitchell and Black's *Freud and Beyond*, "The analyst, like the good-enough mother, provides an environment in which her own subjectivity is on hold" (p. 133, 1995) Reminiscent of the way a mother shows her love by consistently meeting the dependent child's needs, the therapist conveys care by providing unwavering focus and continuity to the patient.

Granted, due to both the human nature of mothers and therapists, and the temporary nature of the primary maternal occupation, the preoccupation cannot be sustained indefinitely. In comparing a therapist's ability to hold a patient it is interesting to note that, similar to a mother's inability to meet a child's needs 100% consistently in a machine-like manner, therapists too are unable to meet the needs of a patient at all times. In fact, according to a recent study of psychoanalysis with young adults, therapists viewed challenging and helping to develop a patient's thoughts about his or her self as critical to change in treatment (Lilliengren & Werbart, 2010). This suggests that in order to create change, it would be ineffective for therapists to meet all of the patient's needs because challenging their perceptions is critical to growth. Slowchower describes the similarities between mothers and therapists with the following quote: "The analyst-patient pair, like the mother and baby, is viewed as engaged in an ongoing attempt to understand and then to meet the patient's needs, and to repair disruptions when they occur" (Slowchower, 1996). As mothers become distracted by their own needs, therapists may too be distracted by thoughts of an earlier patient, or perhaps by their own impending needs. As Slowchower points out, "the patient will ultimately come up against the limits of the analyst's availability,

attunement, and holding capacity” (1996). An entire discourse around rupture and impasse in the therapeutic relationship runs parallel to the notion of a mother being imperfect in meeting the child’s needs. Importantly, much as the mother is still considered “good enough” if she works to manage impingements in her care for an infant, a therapist’s skill and care in working toward repair of a rupture in the relationship can determine for a patient whether the therapist is still “good enough” to collaborate with in treatment. Corresponding to Winnicott’s beliefs around emotional maturation and integration, within the therapeutic relationship it is believed that failures and ruptures can actually facilitate movement forward as the patient becomes more active and independent in the relationship and in determining his own happiness (Elkind, 1992). As considered earlier in the discussion of emotional integration, these impingements upon the mother’s ability to focus absolutely on the child are what lead to the gradual development of independence. Likewise, in the therapeutic relationship Winnicott saw these gentle failures in attunement as opportunity to convey reliability of love from the therapist:

As analysts ... we are all the time failing, and we expect and get anger. It is the innumerable failures followed by the sort of care that mends that build up into a communication of love, of the fact that there is a human being there who cares.  
(Winnicott, 2002, p. 76).

### **Emotional Integration as a Function of Therapy**

In an attempt to understand the function of therapy and its correlations to motherhood, we turn now to several concepts that help to define the usefulness of therapy. Winnicott explained his understanding of therapy in his book *Human Nature* with the following statement:

The main work of psychoanalytic treatment ... comes about through bringing to consciousness that which was unconscious. This is chiefly done through the reliving in

the relationship of the patient to the analyst. The ... [patient] appears to work from consciousness, and feels uncomfortable about that which is unavailable to consciousness. A desire for self-awareness seems to be characteristic... Analysis, for these people, brings increased awareness and tolerance of unawareness. (1988, p.60)

Later in the same book he gives a similar explanation: “psycho-analysis brings about relief in the classical way, by enabling the patient to become conscious of the conflict and to tolerate the anxiety that belongs to a free instinctual expression.” (1988, p.137). Given a Freudian understanding that the material and function of the unconscious is generally unavailable to a person, and Winnicott’s perception that people appear to be working from consciousness, Winnicott is saying that the acknowledgment and catharsis of releasing unconscious material to consciousness via holding and interpretation allow for emotional development. Now, in comparison, consider if you will Winnicott’s view on the process of emotional integration in the infant. For the infant, emotional integration is a means by which the unknown or not understood becomes knowable and understandable; the intolerable becomes tolerable. As mentioned in the initial discussion of Winnicott’s view of emotional integration he believed that the process of emotional integration includes incorporation of id impulses into the control of the ego. The process Winnicott describes within therapy is a striking replica of this process in early childhood.

There are different ways of understanding how this process takes place within therapy. As discussed above, one means for this process is the provision of a holding environment via insight-based interventions, and emotional containment where it was lacking in childhood, a process seen as crucial to the patient’s ability to move forward emotionally. Another way in which the intolerable becomes tolerable is through the lending of ego support to the child/patient. As noted earlier Winnicott heavily credits the mother’s ability to lend ego support to the child as

central to completion of the task of integration. Mothers help infants by supplying their ego strength to the child who has no, or at most, a very weak, ego. At a time when the child has no control over the world, it is the mother's ability to manage the threats and surprises of the outside world that is crucial to a child's emotional development. Analogous to children who are struggling to manage without control over their environment, patients often seek therapy due a sense of loss of control or perceived inability to manage life circumstances. Hans Loewald, a psychoanalyst, theorist and a contemporary of Winnicott's, characterized analysis as, "a period or periods of induced ego-disorganization and reorganization" (1960 p. 17). His conception of therapy and the function of therapy (to "set ego development in motion") (Loewald, 1960, p. 17) help us to clearly see the central role of ego development in overall emotional development. A therapist supplies his or her ego strength to the patient for his use in managing difficult emotions and circumstances, essentially acting as an "auxiliary ego" (Misch, 2000). As described by Misch, "The patient is allowed to use or 'borrow' the therapist's presumably well-working mind and psychological capacities in order to enhance his or her own, relatively deficient, psychic functioning in particular domains." (2000, p. 177-178)

In consideration of the ways in which the therapeutic process of emotional integration is achieved, it is also important to consider the work of Wilfred Bion. Like Winnicott, Bion was British and was a student of Melanie Klein's (Mitchell & Black, 1995). Bion was a member of the British Psychoanalytic Society and led a long and notable career (Fraley, 2008). Perhaps as a result of his own desires to understand experiences in his own life (specifically his military participation in WWI) he was always in pursuit of "truth" in his studies as he believed truth to be at the heart of mental health (Fraley, 2008). He took Klein's ideas about projective identification and applied them to both the infant/mother and patient/analyst dyad in a way that closely

resembles Winnicott's understanding of the function of the maternal auxiliary ego. In line with Melanie Klein's theoretical focus on fantasy in children, Bion pictured the infant as full of disturbing "mental content" over which he had no control (Mitchell & Black, 1995). He believed that this mental content was projected onto the mother who organized it in her own way, and subsequently introjected the material back to the child in a manageable, tolerable form (Fraley, 2008). By engaging in this communication emotional material that was initially intolerable was made *meaningful*, thereby establishing the foundation for the ability of thought (Fraley, 2008). Crucial in this understanding is that, opposed to Klein's view that projective identification was an intra-psychic phenomenon; Bion viewed it as an interpersonal event whereby real and meaningful communication took place between people (Fraley, 2008). Infants without the benefit of this function, Bion believed, were left to grapple with destructive disorganized and distressing content on their own.

Bion recognized a similar process in the therapeutic dyad. In clinical situations he began to notice that often, he personally felt the same struggles and emotions his patients were experiencing (Mitchell & Black, 1995). Bion used the phrases "container" and "contained" to discuss the interaction taking place (Bion, 1962). He saw the "contained" as the fragmentary, intolerable or anxiety-provoking material provided by the patient and came to believe that the therapist actually became a "container" for this intolerable mental content of the patient (Mitchell & Black, 1995, Fraley, 2008, Bion, 1962). The therapist, by acting as a container for disturbing emotional content, allows the patient time for contemplation and processing of the topic without having to deal with the full emotional content on his or her own. More importantly the patient is able to communicate this internal dreadfulness in a real, interpersonal way to the therapist via countertransference (Fraley, 2008). Winnicott inadvertently provides a firsthand



account of his experience of being the “container” in his description of the analysis he did with a young boy. He wrote,

Once I had made this interpretation the treatment had started and all the subsequent material was influenced by the fact that I had entered the boy’s life as a human being who can put things into words, who can deal objectively with the situation that is full of feeling, who can tolerate conflict and who can see what is just ready in the patient to become conscious and therefore acceptable as a self phenomenon. (1988, p. 89)

The way that Winnicott depicts his tasks as “dealing objectively with the situation” and being able to “tolerate conflict” resonate with the meaning of Bion’s container/contained model.

Winnicott asserted that bringing unconscious material into conscious perception was imperative in emotional development; Bion’s theory gives specific language to this transaction and how it takes place. When taking into account the maternal metaphor within the therapeutic relationship, it is interesting to note that Bion chose to use the female symbol to denote “container” and the male symbol to denote “contained” in his writings (1962). Bion developed terminology around the idea of making the unknown known, as this idea was central to his theories around the pursuit of truth and knowledge. He referred to unknown elements that affect psyche and somatic functioning as “beta elements” (Bion, 1962). They can also be understood as “raw emotional experiences” (Fraley, 2008) or “raw fragments of sensation” (Wilson, 2007). Beta-elements can be understood in much the same way as unconscious material. Beta-elements go undetected by a person in their emotional functioning and are indescribable and/or inconceivable or unarticulated by the child/patient. On the other hand Bion conceptualized “alpha-elements” which he defined as – “visual images, auditory patterns, olfactory patterns” which are “suitable for employment in dream thoughts, unconscious waking thinking, dreams...

memory” (Bion, 1962 p. 26.) In his own words he differentiated beta-elements from alpha-elements with the following:

Beta-elements are stored but differ from alpha-elements in that they are not so much memories as undigested facts, whereas the alpha-elements have been digested ... and thus made available for thought. It is important to distinguish between memories and undigested facts- beta-elements... alpha function makes the ... emotional experience available for conscious and dream-thought. (Bion, 1962 p. 7)

He believed that metamorphosis of the nonverbal (beta-elements) into the verbal (alpha-elements) created awareness and knowledge about oneself. This newfound knowledge about oneself stimulates earliest forms of thought in infants and the ability to make meaning out of something that was initially not in conscious awareness (Wilson, 2007). According to Bion the knowledge (alpha elements) gained in this process is also instrumental in beginning to tolerate previously intolerable thoughts or parts of oneself and also provides new perspective and ability to mark and reflect upon an emotional experience (Fraley, 2008). The interactions that transform beta-elements into alpha-elements are achieved in the container/contained relationship, which means that this takes place both in the mother/child and therapist/patient relationships. The book in which these theories of Bion’s are detailed is called *Learning From Experience*; though his writings are extremely dense and complicated, it seems clear that he believed the ability to learn from one’s own experience via transformation of beta-elements into alpha-elements is essential for emotional development and fundamental for the development of thinking about ones emotional experiences.

Much like Winnicott’s process of emotional integration via the mother, Bion’s concepts of alpha and beta elements within the container/contained model actively provides psychological

relief to a patient's distress through catharsis and processing of emotional material. Winnicott believed in the importance of unconscious material being made conscious so that the patient may contend with it intellectually. Bion's container/contained model allows for the same outcome; intolerable material is emotionally felt (via countertransference) and metabolized by the therapist/mother into a tolerable form that is then offered back to the patient/child, which yields the ability for reflection on the part of the patient/child. Fraley (2008, p.65) notes the following: "Knowledge depends on the relationship between the container and the contained, increasing the capacity for understanding as the apparatus for thinking grows." Though she was explicitly discussing Bion's theory of the container and contained in this excerpt, by substituting "mother/therapist" for "container" and "child/patient" for "contained" one could argue that this statement holds true for Winnicott's theories also.

Fascinatingly the study of social referencing in infants supports this concept. In the words of Mayes and Spence (1994), "Social referencing implies not only that the infant expects a response when he looks to the parent, but also that he has the beginning understanding that the parent will respond in a way that is organizing, protective, and facilitative" pg. 9 of 22. Decades later, Winnicott's and Bion's observations are enduring.

When thinking about emotional integration it is also interesting to think about the ways in which both therapists and mothers work with their patient or child developmentally. Winnicott spoke of balancing caring for the child with a tolerable amount of impingements that motivate growth; not enough caring for a child could inhibit the child's growth. On the other hand, caring that goes overboard into the arena of impinging on a child's inherited growth potential is equally detrimental (Winnicott gives the example of feeding a child every time it cries as impingement). A quote from Misch (2000) gives voice to the care that therapists must give in choosing

interventions for patients, and is reminiscent of the balance between caring-for and fostering independence that Winnicott spoke of:

Even when containing the patient, it is important to protect his or her autonomy as much as possible. As soon as the patient is able to regain control, make appropriate decisions, and take appropriate actions, the therapist should relinquish control in those domains.

Often the degree of containment will vary with the patient's condition and the stressors to which he or she is exposed, as would occur with a child. (Misch, 2000, p. 177)

Just as a child develops in accordance with his own unique trajectory, timeline and temperament and mothers must have a sense of what is an appropriate task for their children, therapists must also consider what is developmentally appropriate for their client in order to simultaneously act as a safe space, and also encourage the client toward independence. Sandbank speaks directly to this predicament in her observations that the dilemmas faced by parents in determining what is best for facilitating development of their children minute to minute correspond with the same task faced by therapists with their patients (Sandbank, 1993). She also articulates the dialectic tension both parents and therapists face between providing empathic support and encouraging their child/patient toward individuation (Sandbank, 1993).

### **Further Parallels between Therapists and Mothers**

Another interesting aspect of the maternal metaphor is the ways in which transference and countertransference within the therapeutic relationship at times embody the roles of mother and child. Winnicott pointed out explicitly that he saw the role of the analyst as maintaining a "parent-image" and that in time he saw all patients "...become babies and children in the course of treatment" (2002). Though contemporary theorists are for the most part less vocal than Winnicott in expressing this transference as the solitarily most significant transference

phenomenon, it is nevertheless common for psychotherapists to view themselves in a maternal role respective to their patients and for psychotherapy patients to identify their therapist as a maternal figure (Sandbank, 1993). So common in fact that, “The expression ‘mother-analyst’ is used in a matter-of-fact way by analysts of widely diverging theoretical persuasions” (Sandbank, 1993 p. 9). Patients become comfortable confiding in a mother-like person, seeking wisdom, guidance, support, whereas therapists provide security and help to facilitate emotional development. It is not unusual for this theme to be present; in fact, therapists view it as quite normal. Within contemporary psychotherapeutic and psychological literature the issue of a maternal theme is often discussed in terms of transference and countertransference material. It is common for instances of maternal aspects of therapeutic relationships to be discussed symbolically in case examples as a means to better understand the relationship between patient and therapist. The following excerpts of an analyst’s accounts of clinical interactions with patients are examples of this phenomenon:

I increasingly thought of her as a very small child, almost a baby...I was feeling like an alternative to what I imagined about her real mother...I was allowing her to be that dependent baby, the dependence being acted on in the analysis. (Sandbank, 1993, p. 13)

And,

At the beginning I had the feeling of being with a small child who had received a terrible blow and was reacting by having a temper tantrum, and I felt that the most helpful thing would be to be with him and “hold” him... (Sandbank, 1993, p. 13-14)

Furthermore, “Patients will often compare their analyst (of either sex) to the mother (or parent) they never had and speak of the treatment experience as ‘another chance’ to grow up” (Mayes, & Spence, 1994)

Another noteworthy comparison of the mother/child and analyst/patient relationships comes from Lerner (2005) who pointed out that these relationships serve to define the identity of the mother and the analyst. Just as Winnicott pointed out that there is no such thing as an infant alone, Lerner (2005) calls attention to the fact that a mother does not develop her identity as a mother without first having a child to care for. He compares this with the notion that he as a developing clinician could not create his identity as a therapist without having interactions with patients; the identity development and therefore actions of both mothers and therapists rely upon their child/patient.

It is of great interest in considering this maternal metaphor in psychoanalysis to note that “three founders of child analysis” had either performed analysis on, or had been analyzed by a family member (Rodman, 2003, p.109). Though the practice today would be defined as unethical based on the criteria of a dual relationship of analyst and relative, Melanie Klein analyzed her son, her father Sigmund Freud analyzed Anna Freud, and Hermine von Hug-Hellmuth supposedly analyzed her nephew Rolf (Roazen, 1992, Rodman, 2003). Considering the historical roots of child analysis perhaps the maternal parallels within psychoanalysis should not come as such a surprise.

Given these understandings of Winnicott’s good enough mother, and the parallels between therapists and mothers, what is a good enough therapist? What is a good enough therapy? I will explore these questions through the lenses of attachment theory and relational theory in the following chapters.

## CHAPTER IV

### Attachment Theory and the Good Enough Therapist

#### Historical Background and Theoretical Underpinnings of Attachment Theory

To understand the development of attachment theory, we will now delve into the work of John Bowlby. Like Winnicott, Bowlby was a British psychoanalyst. In a time where psychoanalysis was intently focused on internal mental activities and fantasies, Bowlby's insistence that the external environment mattered in child development (specifically interactions between the mother-figure and child) were not initially well received. Of importance to note, Bowlby was a student of Melanie Klein, who was instrumental in leading the focus of psychoanalysis to child fantasy. Though unappreciated initially, today attachment theory is revered as instrumental in clinical work with a vast array of human populations.

Bowlby prided himself on the development of theory in a scientific manner. He recognized that psychoanalysis was not as straightforward or as clear-cut as other sciences, but nonetheless did his best to base his theory development on scientific findings. As opposed to working backward from a pathological behavior and probing into the past and/or unconscious to discover its origins as psychoanalysts of the time were apt to do, Bowlby prided himself on meticulous observations which then led to his hypotheses about behavior (Bowlby, 1969). He spoke of the matter in his 1988 book, *A Secure Base*,

Instead of starting with the private thoughts and feelings of a patient, as expressed in free association or play, and trying to build a theory of personality development from those

data, I have started with the observations of the behavior of children in certain sorts of defined situation, including records of the feelings and thoughts they express, and have tried to build a theory of personality development from there. (Bowlby, 1988, p. 26)

As both a scientist and a clinician he did his best to achieve a balance between the two fields in his work, giving credit to each, as they were due. Later in the same book he notes,

As practitioners we deal in complexity; as scientists we strive to simplify. As practitioners we use theory as a guide; as scientists we challenge that same theory. As practitioners we accept restricted modes of enquiry; as scientists we enlist every method we can. (1988, p. 43)

In accordance with his emphasis on scientific observation to inform his theory, Bowlby also referred often to the work of Darwin and ethology in general. His writings include frequent and detailed explanations and inquiries into the behavior of birds, monkeys, and many other animals (Bowlby, 1969, 1973). His theory is largely built by looking to nature to supplement his observations of human attachment behaviors and patterns.

This focus on natural and animal behaviors also separated him from psychoanalysts of his day. Whereas most psychoanalysts and theorists of the time kept a Freudian perspective of behavior motivation based on sexual, and aggressive drives or desire to meet basic needs such as the provision of food, Bowlby did not believe that attachment to the mother was decided on these terms. In his first volume on attachment titled, *Attachment and Loss*, (1969) Bowlby discusses at length and goes on to refute “secondary drive theory” which asserts that “primary” drives such as “food, liquid, warmth, and sex” motivate behavior and that social interaction is only secondary to these drives. Bowlby, using Harry Harlow’s famous study of monkeys who preferred feeding with a surrogate cloth monkey mother over a wire monkey mother as a core piece of his



argument, asserts that attachment is not driven by “primary” drives, but instead is, “a system of behavior having its own form of internal organization and serving its own function” (1969, p. 230). Whereas Freud’s use of Darwin’s work saw human behavior as a result of the ego’s attempts at taming underlying animal behavior, Bowlby instead saw human behavior as instinctual, and adapted for survival (Mitchell & Black, 1995). According to Bowlby, the root of adaptive behavior is the “child’s tie to the mother” which he called “attachment” (Mitchell & Black, 1995, p. 136).

In contrast to the secondary drive theory accepted by most others at the time, Bowlby contended that attachment fell into a homeostasis model. He viewed attachment and attachment theory through a control systems approach. Attachment behavior exhibited by the child, along with the behaviors of attachment figures whom the child was acting towards, he believed are enacted in order to maintain a specific balance between “accessibility and distance to the attachment figure” (Bowlby, 1988 p. 29). For example if a child wanders too far from his mother’s reach, the mother will move toward the child to regain an appropriate and protective amount of distance between them. On the other hand, should a mother leave the room or go too far away for the child’s liking, the child will likely engage in attachment behaviors to regain a comfortable amount of distance between them. He saw these behaviors as a means to maintain a safe balance and in no way saw these behaviors as gratifying sexual or “primary” drives as many of his contemporaries believed. Furthermore he believed that “This homeostasis is seen as maintained through psychological representational models (representing the self, the attachment figure or figures) or internal organization” (Bowlby, 1988, p. 29). The next section, which discusses attachment behavior, will help to illustrate the nature of this proposed optimal balance.

## **Attachment Theory**

Much like Winnicott's theories and writings, attachment theory has a practicality about it. Each of Bowlby's terms in discussing attachment are clearly defined and explained. Bowlby's volumes on attachment are thorough and heavily supported by evidence of research and observation.

To define attachment and attachment behavior, it is most useful to consider the words of Bowlby himself. The following quote from his 1988 *A Secure Base* gives a basic, broad, and relatable understanding of attachment theory,

Attachment behavior is any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world...for a person to know that an attachment figure is available and responsive gives him a strong and pervasive feeling of security, and so encourages him to value and continue the relationship. Whilst attachment behavior is at its most obvious in early childhood, it can be observed throughout the life cycle, especially in emergencies. Since it is seen in virtually all human beings (though in varying patterns), it is regarded as an integral part of human nature and one we share (to varying extent) with members of other species. The biological function attributed to it is that of protection. To remain within easy access of a familiar individual known to be ready and willing to come to our aid in an emergency is clearly a good insurance policy—whatever our age. (p. 26-27)

This passage makes several important statements about Bowlby's construction of attachment and attachment theory. First, attachment, particularly to one adult attachment figure who is "better able to cope with the world" serves the purpose of providing protection and security for a young

child. This protection factor inherently makes the relationship valuable and worthy of continued effort. Secondly, attachment behavior is seen as a natural occurrence throughout the life span. Finally, attachment behavior is seen in varying patterns across humans. Before exploring these topics in depth, it is also necessary to take a closer look at attachment behavior.

As noted above, attachment behavior serves the purpose of continuing a relationship that is protective. But what exactly is attachment behavior? Attachment behavior takes many forms. Examples of attachment behaviors include crying, smiling, following, clinging, sucking, and calling (Bowlby, 1969 p. 208). Bowlby divided attachment behaviors into three categories: signaling behavior, which is done to bring the mother to the child, approach behavior, which is when the child attempts to get closer to the mother and a third lesser known type, non-nutritional sucking (i.e. sucking thumb or blanket) (Bowlby, 1969). These behaviors are also called “careseeking” behaviors and their purpose is to elicit a “caregiving” response from the attachment figure. Caregiving responses are considered the reciprocal to careseeking behaviors. A variety of factors can trigger attachment behavior, including the condition of the child (i.e. upset or ill), whereabouts and behavior of the mother (i.e. mother absent or departing), and environmental conditions (i.e. alarming events) (Bowlby, 1969, p. 259). One can easily imagine how careseeking behaviors such as crying, clinging, or even smiling would prompt a parent or other attachment figure to engage caringly and protectively with their child. Bowlby elaborated on the concept further,

As a rule careseeking is shown by a weaker and less experienced individual towards someone regarded as stronger and/or wiser. A child, or older person in the careseeking role, keeps within range of the caregiver, the degree of closeness or of ready accessibility

depending on circumstances: hence the concept of attachment behaviour. (Bowlby, 1988, p. 121)

Though obviously crucial in maintaining a healthy relationship, attachment behavior is not the only variation of behavior that matters in the dynamic between a child and his/her attachment figure (or for that matter, any attachment relationship). Viewing attachment in the framework of preserving homeostasis as discussed earlier, there would be no balance if the child constantly demonstrates attachment behavior with no response. Bowlby's theorizing includes a description of four kinds of behaviors, two belonging to the mother and two belonging to the child: "1) the child's attachment behavior 2) behavior of the child that is antithetic to attachment, notably exploratory behavior and play 3) the mother's caretaking behavior 4) behavior of the mother that is antithetic to parental care" (Bowlby, 1969, p. 237). These behaviors sometimes take place simultaneously and sometimes separate of each other, but their presence are what make up the mother-child interaction in which balance can be achieved. Examples of a child's exploratory behavior might be playing at a far distance from his mother at the playground or engaging with a new person. The behavior of an "ordinary mother" that is "antithetic to parental care" perhaps her disengaging briefly from a crying child, withdrawal, or dislike of contact with the infant, is likely to be neither frequent nor prolonged, and is quickly replaced by care behavior when events require it. In an emotionally disturbed mother, on the other hand, it may interfere greatly with care. Thus, just as an infant's attachment behavior is counterbalanced by his exploratory behavior and play, so a mother's retrieving behavior is counterbalanced by a number of competing, and a few incompatible activities.

(Bowlby, 1969 p. 242)

In this quote we begin to get a sense of how Bowlby relates mental health to attachment; though there are many possible permutations of child and mother behaviors that would create an attachment relationship, only those that have an appropriate balance of careseeking and caregiving are considered healthy.

Though an everyday occurrence, it is important to understand the emotional weight that accompanies attachment behavior. Bowlby writes,

No form of behavior is accompanied by stronger feeling than is attachment behavior. The figures towards whom it is directed are loved and their advent is greeted with joy. So long as a child is in the unchallenged presence of a principal attachment-figure, or within easy reach, he feels secure. (1969, p.209)

Furthermore Bowlby wrote that, "Many of the most intense of all human emotions arise during the formation, the maintenance, the disruption, and the renewal of affectional bonds" (Bowlby, 1979, p. 69) and, "The unchallenged maintenance of a bond is experienced as a source of security, and the renewal of a bond as a source of joy" (1979, p. 69). Considering these statements in a practical manner, the pain caused by separation of parent and child, the grief incurred by the end of a romantic relationship, the sting experienced from an argument with a close friend, or conversely the excitement accompanied by the formation of a new romantic relationship make sense. It is understandable that when identified as a protective relationship, attachment is so strongly valued by children, who are undeniably vulnerable. Bowlby's notion that attachment relationships are a means of survival at the most basic form also brought new insight to the longstanding idea of separation anxiety. Bowlby's perception of separation anxiety is that it is a result of children seeing an *increase in risk* when the attachment figure leaves or threatens to leave, which would cause them to have less protection (1988, p. 30). Not only does

the threat of loss increase anxiety, but an actual loss will lead to sorrow; both anxiety and sorrow are likely to lead to anger (Bowlby, 1969, p.209) This more modern and practical viewpoint is a sharp contrast to Freudian and traditional psychoanalytic interpretations which viewed anxiety as the result of conflicting internal sexual and aggressive drives (Mitchell & Black, 1995).

Through this lens, it becomes evident that emotions and emotional well-being are quite related to attachment. Bowlby writes, “Whether a child or adult is in a state of security, anxiety, or distress is determined in large part by the accessibility and responsiveness of his principal attachment figure” (1973, p. 23). Notably and importantly, the idea of attachment does not end once the child reaches maturity; on the contrary, attachment theory remains applicable throughout the lifespan. The following passage details the importance of attachment throughout the lifespan, and indicates how attachment may shift into adulthood:

During infancy and childhood bonds are with parents (or parent substitutes) who are looked to for protection, comfort, and support. During healthy adolescence and adult life these bonds persist, but are complemented by new bonds, commonly of a heterosexual nature... the relationship exists in its own right and has a key survival function of its own, namely protection. Initially the only means of communication between infant and mother is through emotional expression and its accompanying behavior. Although supplemented later by speech, emotionally mediated communication nonetheless persists as a principal feature of intimate relationships throughout life...the capacity to make intimate emotional bonds with other individuals, sometimes in the careseeking role and sometimes in the caregiving one, is regarded as a principal feature of effective personality functioning and mental health (Bowlby 1988, P. 121).

This description highlights the fact that though attachment still clearly exists in adulthood, it will present itself differently over time; romantic relationships and friendships become equally or more important than attachments to family members, and people may begin primarily caregiving as opposed to careseeking. Likewise means of communicating via attachment behaviors will modify to behaviors that are age-appropriate as an individual ages.

Perhaps the most significant notion of the above passage is the piece that asserts that the ability to communicate emotionally is central to intimate relationships, and in turn mental health and effective personality functioning. This idea has led to many hypotheses and the study of attachment patterns, and their outcome in terms of mental health. Starting with Mary Ainsworth and the “Strange Situation” she created in her lab, for years psychologists have been observing the patterns of interactions between children and their mothers in search of answers about attachment style, and how it affects mental health.

Using the work of James Robertson as a guide, the following three stages of separation were conceptualized based on observations of two and three year old children experiencing temporary separation from their mothers in residential nurseries, being cared for by unfamiliar adults (Bowlby, 1969). The three stages determined to occur following separation from the mother are “protest”, “despair” and “detachment”. These stages occur sequentially beginning with protest; in the protest stage “the young child appears acutely distressed at having lost his mother and seeks to recapture her by the full exercise of his limited resources” (Bowlby, 1969, p.27). This stage may include a variety of behaviors including loud crying and seeking his mother, meanwhile rejecting others who offer to care for him. The despair phase which follows “suggests increasing hopelessness” (Bowlby, 1969, p. 27); the child can be withdrawn and appears to be mourning. Finally, in the phase of detachment, the child begins to accept help from

alternative caregivers and may appear to be less distressed overall. However, the difficulty of this stage is clear when he again reunites with his mother but “seems to have lost all interest in her” (Bowlby, 1969, p. 28).

In Mary Ainsworth’s initial studies of children’s responses to their mothers’ departure, she developed a security-insecurity scale to gauge the attachment between mother and child (Bowlby, 1969). She used Robertson’s conceptualization of protest, despair, and detachment to create her initial measures of secure and insecure attachment styles. The following gives examples of children whose behaviors indicate secure and insecure attachment, respectively:

A child of twelve months who can explore fairly freely in a strange situation using his mother as a secure base, who is not distressed by the advent of a stranger, who shows awareness of his mother’s whereabouts during her absence, and who greets her on her return, Ainsworth rates as securely attached, whether he is distressed by his mother’s temporary absence or can weather brief periods of it without upset. At an opposite extreme, and rated as insecurely attached, are infants who do not explore even when mother is present, who are much alarmed by a stranger, who crumple into helpless and unoriented distress in mother’s absence, and who when she returns may not greet her.

(Bowlby, 1969, p. 338)

Bowlby and Ainsworth postulated that mothers who are “sensitive, accessible, and responsive” to their children ultimately help to develop “a limited measure of self-reliance” in their child by the first birthday (Bowlby, 1988, p. 48). On the other hand, “insensitive” mothers who may be preoccupied, interfere with, ignore, or reject their children “are likely to have children who are unhappy or anxious and difficult” (Bowlby, 1988, p. 48). As explained by Mitchell & Black



(1995, p.137), “Emotional security is a reflection of confidence in the availability of attachment figures, which is built up gradually through early childhood experiences”.

Moreover, attachment styles are seen as ongoing. Bowlby noted that the pattern of interaction visible in a one year old child is, “sufficiently similar to what is seen of personality development and of parent-child interaction in later years” and because of this believed that it is likely that “the one is the forerunner of the other” (Bowlby, 1988, p.48) Bowlby claimed that attachment styles, “tend to persist” over the years due to the cyclical pattern of expectations held by each member in the relationship; a pattern which is satisfactory to both members is likely to be stable, whereas dissatisfaction inevitably leads to attempts at changing the pattern, which makes it more unstable (Bowlby, 1969). Despite the inherent perpetuation of an attachment pattern, Bowlby saw the possibility for a shift in relational patterns. He did not see attachment patterns as permanent, but rather enduring unless external events or individual behaviors changed the interaction. He saw that the pattern of interaction itself, “becomes increasingly a property of the child himself, which means that he tends to impose it, or some derivative of it, upon new relationships such as with a teacher, a foster-mother or therapist.” (Bowlby, 1988, p. 127)

The earliest work in attachment, including the work by Ainsworth, led to the identification of three attachment styles or patterns: secure, anxious-resistant or ambivalent, and avoidant (Levy, Ellison, Scott, & Bernecker, 2011). Later research has expanded upon these original types and uses varying terminology to refer to them and the others that have been created. One such attempt at categorizing attachment style was by Bartholomew and Horowitz (1991). They proposed a model that uses four attachment patterns which are determined based on the dimensions of a person’s model of self, and model of other. The following diagram has been

recreated from their 1991 publication, *Attachment Styles Among Young Adults: A Test of a Four-Category Model*:

MODEL OF SELF (Dependence)

	Positive (low)	Negative (High)
Positive (low)	<p>CELL I</p> <p>SECURE Comfortable with intimacy and autonomy</p>	<p>Cell II</p> <p>PREOCCUPIED Preoccupied with relationships</p>
MODEL OF OTHER (avoidance)		
Negative (high)	<p>CELL IV</p> <p>DISMISSING Dismissing of intimacy, counter-dependent</p>	<p>CELL III</p> <p>FEARFUL Fearful of intimacy, Socially avoidant</p>

(Bartholomew & Horowitz, 1991, p. 227, figure 1. Model of adult attachment)

The authors explain that their label of “secure” “indicates a sense of worthiness (lovability) plus an expectation that other people are generally accepting and responsive”; preoccupied “indicates a sense of unworthiness (unlovability) combined with a positive evaluation of other”; fearful indicates “a sense of unworthiness (unlovability) combined with an expectation that others will be ...untrustworthy and rejecting”. Finally, the category of “dismissing” indicates “a sense of love-worthiness combined with a negative disposition toward other people” (Bartholomew & Horowitz, 1991, p. 227).

Over the years, a key measure of attachment style within the field has been the Adult Attachment Interview (AAI), developed by Mary Main and her colleagues. This one-hour interview style measure assesses an adult’s early relationships, early attachment style, and adult personality to make a determination about their attachment style. It originally used the three

categories, “secure/autonomous, dismissing, and enmeshed/preoccupied” which correlate with the original categories by Main of secure, avoidant, and anxious/resistant. Later, two more attachment categories were added to the AAI, “unresolved” and “cannot classify”. In later work, Main referred to these same later categories as “disorganized/disoriented” (Levy et al., 2011). Bartholomew and Horowitz’s four classifications secure, preoccupied, fearful, and dismissing, are said to correlate with similar conceptualizations; securely attached, ambivalent/enmeshed/preoccupied, avoidant, and dismissing/detached, respectively (1991).

Irrespective of the differing names given to these nuanced concepts, it is clear across the board that a secure attachment is viewed as most beneficial in terms of mental health. A secure infant, after a brief separation from his mother, welcomes his mother’s return, exhibits careseeking behaviors toward her, and allows himself to be comforted by her (Bartholomew & Horowitz, 1991). Generally, a child with ambivalent style attachment (which we know now has also been labeled preoccupied or anxious-avoidant) will be ambivalent towards his mother especially after separation, whereas an avoidant style attachment means he will generally avoid his mother after separation (Bartholomew and Horowitz, 1991). Disorganized attachment, one of the newest classifications, has been associated with complex trauma and/or early trauma. As indicated by Bowlby’s writings, these patterns are expected to serve as prototypes, and replicate in subsequent adult relationships unless interrupted. Therefore, it is clear that creating a secure attachment in early childhood is ideal.

### **Attachment Theory, Mothering, and Therapy**

As can be seen from the preceding examination of theory, mothers serve many functions through the perspective of attachment. First, as the most probable main caregivers, mothers serve the primary and naturally satisfying need of establishing human connection with their children.

They protect, ensure survival, and in many ways mediate the threats and surprises of the surrounding environment. Mothers, once attachment has been established, eventually become a “secure base” from which a child can explore, and subsequently grow; there is comfort gained from maintaining proximity to one’s mother, but also the child feels confident to experiment and learn. Finally, the pattern of interaction built between mother and child is likely to set a precedent for interactions in later emotionally significant attachment relationships.

Remarkably, a relationship with a therapist can also accomplish the tasks fulfilled by mothers. A relationship with a therapist can be for some, the sole meaningful human relationship in their lives at a given time. People may come to therapy when they feel they cannot relate to others or have a hard time interacting, thereby having the primary need for social interaction met by the relationship with the therapist. A therapist can help a patient to manage threats from the outside environment. In serious cases, and in line with the idea of attachment as protective and survival-based, a therapist may even literally protect a patient from himself if he is self-harming or suicidal. In terms of becoming a base for exploration, a therapist often encourages self-reflection, and experimentation with new ways of being, coping, and behaving in order to foster emotional growth. Bowlby wrote,

This concept of the secure personal base, from which a child, an adolescent, or an adult goes out to explore and to which he returns from time to time, is one I have come to regard as crucial for an understanding of how an emotionally stable person develops and functions *all through his life*. (1988, p. 46)

Applying this to the therapeutic relationship, it can be easily imagined how the therapist can serve as this secure base; often a patient will call the therapist in a time of need, or schedule an urgent appointment as a means of reestablishing a comforting connection. Ongoing appointments

serve as regular check-ins with an emotionally significant and protective person. Finally, and perhaps most influentially, the relationship with a therapist gives an opportunity to form a new attachment, and more importantly, nurture a new pattern of attachment that can be applied to other relationships. For example an insecurely attached person who hesitantly seeks treatment only in crisis or sporadically, may learn to seek support from the therapist in an increasingly reliable manner over time as the therapist is viewed as a secure base. Changing the way one relates in this manner, in other words, developing a secure attachment, has the potential to translate into other relationships in the patient's life.

In considering the therapeutic relationship as an attachment relationship, it is useful to consider the different types of attachment styles, and how they might appear in therapy. For example, a securely attached patient likely finds himself comfortable in the presence of the therapist. A person securely attached to their therapist may feel protected or held by their time with the therapist and does not hesitate to seek help/protection/regulation from the therapist, as it is needed.

Insecurely attached therapeutic relationships may come in many varieties. Someone who is ambivalent, enmeshed, or preoccupied, because of his low self-regard and positive regard for others, is likely to want to please the therapist. As they are exceedingly concerned with creating a successful relationship, these patients may want to stick to more lighthearted or superficial topics so as not to risk upsetting and pushing away the therapist. Additionally these patients are unlikely to confront the therapist when upset or hurt by the therapist, further denying access to their own feelings, which they perceive as unworthy. In this case it is important for the therapist to hold the patient's anxiety about rejection, and prove to the patient that expression of difficult emotions is tolerable, and not reason enough to terminate the relationship.

An avoidant or fearful patient may have social anxiety. A negative view of self, combined with a negative view of others, is likely to put the avoidant patient into hopelessness about the success of treatment. This patient might view himself and his efforts as worthless, and also view the therapist's efforts at helping him to be not worthwhile or pointless. This increases social anxiety in that the patient is always predicting failure of interpersonal relationships. This prediction then begins the cycle of avoidance, which ultimately fulfills the prediction. In this scenario a therapist might feel herself struggling to try and motivate or engage the patient in the treatment due to the patient's deep-seated doubt of the success of the relationship.

Finally, in the case of a dismissing or detached person, the therapist may seem unimportant or insignificant to the patient. The patient's high regard of self and dismissal of need for intimacy with others allows the patient to continue on a falsely independent path. These patients will often struggle to build insight into their own patterns or behaviors, and likely reflect on the wrongdoings others have committed against them. The therapist in this situation might feel powerless to connect with the patient who does not necessarily view her input as valuable.

Much has been written on the subject of the therapist serving as a new attachment figure. In 1995 Barry Farber, Robin Lippert, and Debra Nevas applied Bowlby's conceptualizations of functions served by a maternal attachment and applied them to the therapeutic relationship to determine how, if at all, therapists can serve as attachment figures. Specifically they used, "therapist as wiser and stronger", "therapist as a secure base for exploration", "therapist as insurer of survival", "therapist as a specific focus of attachment behavior", "therapist as an attachment figure of long duration", and "therapist as an object of intense affect during the formation, maintenance, disruption, renewal and loss of the relationship" as their categorical criteria for arguing how a therapist might or might not function as an attachment figure (Farber,

Lippert, & Nevas, 1995). They operated from an understanding that the therapeutic relationship is affected by “temporal, financial, structural, and ethical boundaries that render it significantly different from childhood attachment relationships” (Farber et al., 1995, p. 204). They concluded that overall, despite differences between mother-child and therapist-patient pairs including lack of emotional reciprocity (which may affect the strength of the relationship), a more objective relationship, and lack of lifetime duration of the relationship, therapists largely serve as attachment figures much in the way mothers do (Farber et al., 1995, p. 204).

The theoretical application of Bowlby’s ideas on attachment to the therapeutic relationship is supported by research focusing on the therapeutic relationship from the client’s perspective. Using both quantitative and qualitative analysis, Skourteli and Lennie (2011) found evidence derived from client sources supporting the idea that client attachment is reenacted with the therapist. In interviews clients discussed topics that were later categorized into the following groups: “The therapist as a secure base for exploration”, “Transference- relatedness”, “therapist as containing and as providing a holding environment”, “therapist as wiser and stronger” and “therapeutic boundaries”- all issues surrounding attachment. As proposed by Bowlby, attachment style is generally long lasting, however there is occasion for alteration should a change in behavior or external events greatly affect the relationship. Direct quotes from patients about their therapists such as, “I did at first worry about her, cause when I meet new people I tend to want to look after them” and “I didn’t trust her at all when I first met her, not because of her but just because I don’t until they prove me wrong” indicate a strong likelihood that patients apply past relational experiences and expectations, or in other words, attachment style, to a new relationship with their therapist (Skourteli & Lennie, 2011).

Additional research reflects similar implications. In a study comparing adult attachment to a primary attachment figure other than a therapist to attachment to the therapist, it was found that, “the features characterizing the therapy relationships were in many respects the same features that characterized the respondents’ relationships with their primary attachment figures” (Parish & Eagle, 2003). The exception to these findings was an unexpected general lack of protesting at separation, which is usually present with attachment figures, especially in early childhood. In infancy protest to separation often includes crying or clinging to the mother. Though these exact behaviors are unlikely to occur in the therapeutic relationship, one could argue that patient protest to the therapist’s departure (for weekends or vacations for example) may be an overlooked example of patient protest to separation. It is possible that these feelings of protest have been overlooked if they are not called to the attention of the patient. Furthermore, this study, through strong correlational findings, suggested that,

Therapy may facilitate security of attachment and a patient’s ability to rely on others, not just on the therapist. Long-term psychotherapy influences a person’s way of relating to others, expressed, in part, in his or her attachment style. As the patient’s confidence in the reliability of the therapist increases over time, his or her confidence in the reliability of others also increases. (Parish & Eagle, 2003, p. 281).

They also found that duration and frequency of therapy were associated with a stronger attachment. This research explains precisely how, therapists might over time influence and actually create an attachment with a patient that could alter their previous attachment style. It has been asserted within the literature that an attachment with a therapist is created over time “in a series of sequential but overlapping phases” determined by emotional, behavioral, cognitive, and physiological events including “Preattachment”, “Attachment-in-the-Making”, “Clear-Cut



Attachment”, and finally, “Goal-Corrected Partnership” (Obegi, 2008). Progression through these stages brings a therapist from a possible attachment figure, to a full-blown attachment figure from whom a patient will eventually develop an internal working model; this in turn will help to create ability for therapeutic change (Obegi, 2008). Related formulations suggest that a “relationship building incident” where the therapist is perceived as helpful, understanding, safe, etc. (for example when a therapist provides validation of a client, shows unexpected non-judgment, helps a client come to a decision or remember a blocked experience) are crucial for beginning to attach to one’s therapist (Janzen, Fitzpatrick & Drapeau, 2008).

Though attachment theory and its implications within mothering and therapy are complex and relevant, they are not all encompassing. What the detailed focus on attachment relationship fails to recognize is the more nuanced versions of internal processes within individuals. Focusing solely on the dynamics between a person and his attachment figure leaves us wondering what the individual’s experience is both inside and outside of the relationship. What internal experiences, feelings, or beliefs lead the person to make the behavioral (and attachment behavioral) choices he makes? Are there factors outside of social motivation and protection that motivate behavior? Is there anything that motivates the behavior of the attachment figure that is not directly complementary to the attachment behavior? Bowlby’s formulations simply cannot answer these questions completely. Though there is definitely an esteemed place in theoretical body of work for Bowlby’s conceptualization of attachment relationships, it would be inaccurate to assume that attachment theory covers all pertinent angles of the maternal and therapeutic relationships.

### **Bowlby and Winnicott: Similarities and Differences**

In many ways, Winnicott and Bowlby presented very similar theories. Perhaps largely as a result of their similar early experiences, upbringings, and psychoanalytic trainings, their

theories have much in common at the outset. Both Winnicott and Bowlby were British, and from middle-class families (Issroff, 2005). They were born only eleven years apart, Winnicott being the elder of the two (Issroff, 2005). Both studied natural sciences, followed by medical school at Cambridge, and both served time in the Navy (Issroff, 2005). Additionally both theorists became child analysts, underwent analysis with the same person (Joan Riviere), and even shared a mentor, the student of Riviere, Melanie Klein (Issroff, 2005). Without question, it seems their backgrounds both personally and academically, would have prompted similar theoretical conclusions. Indeed it seems they did. The following section will look at both the similarities and differences between theories of Winnicott and Bowlby.

Bowlby and Winnicott were a part of the time where theoretically, most psychoanalysts followed Freud's beliefs devoutly, yet some were beginning to take slightly differing paths. Winnicott and Bowlby can be categorized as some of the first to emphasize importance of the external environment in early childhood development as central to mental health. It has been hypothesized that perhaps their mentor Melanie Klein, who focused so intensely on internal "phantasy" of the child (Mitchell & Black, 1995), inspired Winnicott and Bowlby to look beyond the internal world of the child to the external environment for answers (Issroff, 2005). Both focused on an important figure, generally at first the mother, as essential in creating and providing a facilitating environment for emotional regulation and well-being.

Though similar, Winnicott and Bowlby have slightly differing views on how creation of a safe and facilitating environment is accomplished. For Winnicott this comes in the form of the "holding environment"- a physical and mental space created by the intentions of the mother in her primary maternal occupation. Bowlby's focus on the environment is in form of relationship; he believes the atmosphere created by a secure, protective, and predictable relationship can

determine well-being, while an insecure primary relationship that leaves a child vulnerable and confused is reason for concern. In both cases, it is the role of the mother, or of a mother substitute to mediate the environment in some way that makes it accommodating to the child. Winnicott speaks of meeting a child's needs, interpreting the needs correctly, and providing for the child with the optimal level of focus (which changes throughout the lifespan based on the child's level of "dependence"). Intrusions or "impingements" upon this process can damage the optimal environment. Emotionally the mother figure is crucial in mediating between the external world and the child's internal world in order to process and deliver stimuli to the child in an appropriate and tolerable manner. This process, according to Winnicott, is fundamental to mental health and the ability to regulate emotion. For Bowlby, the role of the mother is similar in that the mother provides a protective barrier between the external world and her child, though she is motivated by desire to protect her child, as opposed to a "primary maternal occupation" (the reader will remember from discussion in the last chapter that the primary maternal occupation is seen as the time when the mother naturally and involuntarily has her focus on the needs of the child and has increased attunement with the child in infancy and early childhood). One simple difference is that Bowlby attributes more responsibility to the actions or behavior of the child than does Winnicott. A child's engagement in attachment behavior is seen as equally as important to the mother's reciprocal caregiving behaviors in maintaining a healthy relationship. For Winnicott, the child's subjective internalizations of the mother are more important to well-being than the actual mother is.

Both see maternal caregiving and provision as a natural, instinctual process; Winnicott discusses the ordinariness of the activities of the mother, while Bowlby more directly attributes caregiving to biological, evolutionary and ethological roots. Additionally, there is a level of skill

involved in facilitation of healthy emotional development; neither denies that there are difficulties inherent in motherhood.

One difference between the theorists is the way in which longevity of the relationship between mother and child is addressed. Whereas Winnicott proposes a model of *dependence on* the mother, which eventually, ideally, moves to *independence from* the mother, Bowlby views securely attached relationships as necessary and central to emotional well-being throughout the lifespan. Granted, actual attachment behaviors to engage in and maintain relationships will change with age (as will the primary attachment figure), but the importance of a secure relationship never goes away. In fact, Bowlby proposed his ideas on attachment theory in direct opposition to a model of “dependence” (Bowlby, 1958, 1969, 1988). It is interesting to consider though that for both, regardless of longevity, there is clear central importance of the interpretive and regulatory relationship with the mother.

Another important likeness is the emphasis put on consistency of the external environment. In facilitating emotional regulation of the child, both Winnicott and Bowlby indicate that irregularity and unpredictability are harmful and predicting of emotional distress. Developing capacity for emotional regulation of the self is a direct aim of mothering according to Winnicott. Though Bowlby does not discuss it in quite those terms it can be easily argued that emotional regulation, via secure attachment relationships, is accomplished. The ability to be confident in and soothed by the actions of another stronger, wiser, reliable, protective person is undoubtedly comforting. More specifically Bowlby argues that gaining the ability to tolerate the ambivalence of caring for and loving someone but also simultaneously hating and being angry with them is key to mature relationships (Bowlby, 1979). He believes that conflict is natural state that must be learned to cope with, and an attachment relationship can “make it easier or more

difficult for a child to grow up capable of regulating this conflict in a mature and constructive way" (Bowlby, 1979, p. 3). In this manner, emotions are regulated through the primary attachment relationship.

In a therapeutic setting, therapists serve to provide correctional experiences through both theories. According to Winnicott, a therapist has the potential to meet prior unmet needs, to "hold" a patient as he had not been held before and amend the failures of past care. Though not as literal in terms of changing a past event, attachment theory posits a transformative effect in therapy based on improvement of interactional style with the therapist.

Theoretically, though coming from very similar backgrounds, there do seem to be important differences between Winnicott and Bowlby that they acknowledged themselves. Whereas Bowlby openly acknowledges his admiration of Winnicott and his work, Winnicott was not as openly supportive of Bowlby, and even regularly criticized his work (Issroff, 2005). Bowlby's opinion of the matter is clear in the statement he made that, "I always held the view that Winnicott and I were singing the same tune. We were essentially giving the same message, but again he didn't like my theoretical ideas" (Issroff, 2005, p. 72). Though Winnicott gave him credit for doing "more than one man's share of drawing the world's attention to the sacredness of the early holding situation and the extreme difficulties that belong to the work of those who try to mend it" (Issroff, 2005, p. 142), he objected the simplicity with which Bowlby theorized about human behaviors. Though he did not completely ignore the internal world, Bowlby's work was focused more than any other analyst of his time on external factors. While Winnicott in many ways held similar beliefs, he was not ready to forgo the complexity of the internal workings of the human mind to put emphasis on external environment in quite the way Bowlby did. Likely as a result of Bowlby's focus on scientific method, Darwin, and observation of

animal behavior (as opposed to Winnicott's preference for observation within his own clinical work), Bowlby's conclusions were much more direct, simplistic, and scientific than were Winnicott's complex and subtle observations (Issroff, 2005).

### **Attachment Theory, Winnicott, and the Good Enough Therapist**

Among these similarities, and differences, what are the important implications for clinical work and the therapeutic situation? What are good enough therapeutic techniques in relation to the similarities between mothering and therapy through Winnicott's theories and also through attachment theory? The following section will briefly synthesize the take-home message that results from the overlaps in theories.

Before addressing the specifics of what the two theories hold common though, it is important to quickly think about the practicality of applying theory in clinical practice. It is of note that some have critiqued attachment theory as difficult to use clinically as a tool within the therapeutic relationship (Issroff, 2005) while others find Bowlby's concepts extremely helpful. Likewise, many find Winnicott's ideas informative within the therapeutic setting. It also has been suggested that as opposed to thinking clinically through only a lens of attachment, it is more helpful to a clinician to formulate a case along the lines of an understanding of early attachment much in the way one might with a clinical diagnosis (Larsson, 2012).

Regardless of how one applies a technique in the clinical hour, it seems that the following principles are of greatest important to both Winnicott and Bowlby in terms of achieving mental health. Of both men it has been acclaimed that "the ramifications of their respective contributions continue to reverberate and stimulate diverse avenues of fertile exploration in many fields...The work of both men continues to influence researchers, thinkers, and our understanding across a wide spectrum of endeavor" (Issroff, 2005, p. 149-150). Taking into

consideration the above in-depth review of Winnicott's theories on development and Bowlby's attachment theory, it appears the combination of the following qualities and abilities create a good enough therapist:

1. *Creation of a safe/protecting/holding situation/environment.* Like children, patients are often vulnerable, in need of protection, and seek stability and containment. A mother or therapist has the ability to mediate the environment for the patient to create safety and stability that "holds" or "protects" them. As noted by Weich (1990, p. 137), "The good enough analyst should provide a facilitating environment for the patient that promotes maturational growth and development". In order to create a sense of safety it is of utmost importance to *be consistent with and attentive to the needs* of the patient. Failure to meet or notice needs sufficiently (impingements) may create unhelpful conflict in the relationship, or indicate to the patient that in fact he cannot trust the relationship. Navigating these needs and responding to them appropriately develops safety for the patient and contributes toward mental health. This is a balance where "too great a response by the analyst to the patient's needs, or too little, can do damage... 'good enough' in this realm is best" (Weich, 1990, p. 137).
2. *Helping to facilitate/develop emotion regulation in the patient.* This can be accomplished through modeling or teaching behavior, through facilitating exploration, and by using specific language and interpretations to help the patient reflect on their abilities to cope with emotion. Similarly, the relationship with the patient can model interacting and coping in ways that support healthy emotion regulation. The ability to regulate emotion leads to mental health.

3. *Helping to reshape the developmental process.* The good enough therapist is aiding in development that has gone awry (Weich, 1990). Important within this concept is meeting the patient where he is emotionally and developmentally. Activities and behaviors in mothering vary depending upon the age of the child (Francis-Connolly, 2000). Just as a mother would not try to help an infant to walk because it would be inappropriate to their development, a therapist must not get ahead of the patient developmentally. Whereas Winnicott attests to the power of “holding” a patient in the moment that their caregiver failed in order to facilitate further development, Bowlby points to building a relationship that will propel healthy development by creating an improved internal working model. Therapists must too be able to assess the patient’s developmental location and/or trauma, and proceed accordingly to progress development to an age appropriate level. Providing holding and stability are often the cause of moving development forward.

These three tasks appear to be a general guideline for good enough mothering and therapy. Though each theory is specific within itself and can provide more insight individually into how these tasks might be accomplished, it seems they are a good start to providing a caring, protective, and emotionally regulating relationship. That being said, the concepts in the following chapter are sure to add another dimension of complexity to the good enough mothering and therapeutic relationships.



## **CHAPTER V**

### **Relational Theory and the Good Enough Therapist**

#### **Historical Background and Theoretical Underpinnings of Relational Theory**

To begin our review of relational theory, we must first address a few foundational ways in which relational theory differs greatly from the previous theories and concepts addressed in this paper.

First, we note that “relational theory” is not one particular theory coming from a specific theorist, but rather, is the work of many theorists whose work overlaps in many ways. When reading the work of authors who have written about relational theory, the reader comes across many related concepts. The early relational theorists “lived and worked in different times and different places. They were not necessarily aware of each others’ ideas or clinical findings” and because of this may not even share techniques or procedures (Greenberg & Cheselka, 1995, p. 56). There is not one “correct” relational theory, but instead a collection of many ideas stemming from similar theoretical positions- this entire body of work is what is known to be relational theory. Due to the vast variety of ideas and nuanced details within many relational theories, this chapter will focus on concepts that are generally common in most relational ways of thinking.

Second, unlike the previous theories and concepts reviewed in this paper thus far, relational theory is not a theory of development. Whereas previous chapters focused on Winnicott and Bowlby’s respective ideas about child development and the psychological effects of development on adult behaviors and functioning, relational theory will not provide input on

these matters in such a straightforward fashion. Most relational theory deals directly with the therapeutic situation, and conceptualizes how humans interact psychologically with other humans. According to Aron, (1996) “Object relations theorists tend to emphasize the role of early relationships in organizing the internal structuralization of mind, whereas interpersonal theorists...tend either to disregard development or to view development as nothing but a series of relationships” (p. 40). For this reason the following discussion of relational theory will not discuss childhood development in the same manner as was done with attachment theory. Understanding the theoretical underpinnings of relational theory helps to clarify why relational theorists spend relatively little time on the topic of childhood development.

For many reasons, the best way to describe the development of relational theory is that it is built upon and in contrast to classic Freudian psychoanalysis. Traditional Freudian psychoanalysis and the theoretical developments that followed in Freud’s lead for decades have a certain flavor to them; Freudian psychoanalysis posits an objective analyst who is strict, opaque and considers transference an unfortunate occurrence in the therapeutic relationship that must be dealt with. Relational therapists view themselves first and foremost as subjective and use both transference and countertransference as central to the therapeutic work. Most importantly Freud was focused on a person’s internal psychology, what went on *within* a person (Greenberg & Cheselka, 1995). Over the years as important thinkers began to recognize the psychological significance of external factors such as real events, and relationships in a person’s life, it became clear that drive theory and ego psychology, which have their foci on internal psychological events, could no longer account for the variety of human behaviors, thoughts, feelings, and occurrences. As this recognition became clear in the field of psychoanalysis,

the emphasis shifted to what went on *between* people. We are, from the moment of birth, immersed in relationships with other people. The qualities of these relationships must be decisive determinants of who we become, how we think about ourselves, how we negotiate the course of our lives...attempts to intervene therapeutically rest on the possibility of creating a new sort of relationship, one that has the power to alter the course that the patient has been following. (Greenberg & Cheselka, 1995, p. 56)

Eventually, recognition of the importance of interactions between people and the innate significance of social relationships led to “interpersonal” and “intersubjective” schools of thought. Ultimately it is the extension of these theories from a single theory of mind perspective that led to relational theory, in its many forms, as it is understood today. What separates relational theory from interpersonal theory which focuses solely on relationship, is that relational theory keeps a Freudian spirit of acknowledging intrapsychic events, however it adds on a more diverse appreciation for relationships as they exist both in the world with others, and intrapsychically. Greenberg and Mitchell (1993) as cited in Greenberg and Cheselka (1995) assert that the relational model “is defined by a shared belief in the developmental, structural, and therapeutic importance of relationships” (p. 56). Aron describes this theoretical shift with the following observation: “In keeping with the postmodern trend, psychoanalysis went from being coherent and unitary to being multiple and diverse”. (Aron, 1996, p. 2)

### **Relational Theory**

Starting with Freud, psychologists and psychoanalytic thought tended toward the belief that a successful individual was one who moved through childhood and eventually individuated appropriately and in a timely manner. In many ways, success meant independence, usually particularly from the mother or parental figure. Varying theories postulate about a variety of

conflicts or obstacles that may arise and inhibit or delay an individual's journey toward independence, but historically most developmental theories agree that the end goal is an independent individual. Relational theory differs from these theories essentially by changing the parameters for individual psychological success. From a relational perspective traditional independence is not the model of health, rather connection and relationship are indicative of psychological health. Spencer, coming specifically from a Relational Cultural Model perspective, explains how relational theories think about relationships as a function of psychological health:

Relationships with others are not viewed as a vehicle for reaching the developmental goal of an individuated self, but rather the active participation in mutually empathic relationships itself becomes the goal of psychological development...psychological health is understood to be a function of participation in relationships with others in which mutually empowering connections occur...connections, disconnections, and reconnections in relationships are viewed as the core developmental processes. (Spencer, 2000, p. 6)

Furthermore, Spencer (2000) continues by asserting, "Psychological health is an outgrowth of this type of connection with others while psychological distress develops in response to repeated and chronic patterns of disconnection" (p. 6). Jessica Benjamin (1988), also an important contributor to relational thought, takes a similar perspective:

Once we accept the idea that infants do not begin life as part of an undifferentiated unity, the issue is not only how we separate from oneness, but also how we connect to and recognize others; the issue is not how we become free of the other, but how we actively engage and make ourselves known in relationship to the other. (p.18)

Relational thinkers believe that relationships contribute to psychological growth, and are opposed to the notion that being an emotionally/psychologically self-sufficient individual is an achievement. In this view people are not seen as solitary but are naturally and undeniably connected with others. Likewise affect does not come from a person singularly but is developed out of complex situations including interaction with others (Mitchell, 2000). In this way, interpersonal dynamics are of central importance to relational theory.

Other crucial differences between traditional psychoanalysis and relational theory include the ideas of subjectivity and intersubjectivity. As stated above, Freudian psychoanalysis and psychoanalysis for many years following, saw the role of the therapist as one of an objective observer. In traditional frameworks an analyst was seen as having the capacity to view the patient through an objective lens, which was seen as a beneficial, professional, and scientific stance. Though this logic was held onto strictly for a long time, relational theory recognizes and draws attention to the undeniable subjectivity of a therapist. Just as a patient has his own subjective experiences, views, beliefs, and feelings, so too does the therapist. Berzoff (2011) describes therapist subjectivity in the following excerpt:

The therapist arrives with a complex social history (gender, race, class, religion, age, ability, and culture), and these are always interacting with her client's social history in ways that mutually influence one another. All of these feelings, conflicts, histories, desires, and social identities constitute subjectivity. (p. 232)

Berzoff (2011) also notes that a therapist's subjectivity "cannot be hidden" (p. 231). As Berzoff implies, a therapist's subjectivity inevitably interacts with that of a patient resulting in "intersubjectivity". In contrast to the object relations notion of people relating to other "objects",

The intersubjective view maintains that the individual grows in and through the relationships to other subjects. Most important, this perspective observes that the other whom the self meets is also a self, a subject in his or her own right. It assumes that we are able and need to recognize that other subject as different and yet alike, as an other who is capable of sharing similar mental experience. Thus the idea of intersubjectivity reorients the conception of the psychic world from a subject's relation to its object toward a subject meeting another subject. (Benjamin, 1988, p. 19-20).

This shift from therapist-as-object to therapist-as-fellow-human-subject alters the therapeutic relationship dynamic from one of healer/expert (therapist) working with someone in-need-of-healing (patient)- it goes from a deficit model loaded with power dynamics- to a more equal playing field where both people in the relationship are viewed as human participants. Benjamin (2006) has also conceptualized intersubjectivity as a "two-way street". She explains, "By this I mean to emphasize the necessity of grasping reciprocal action—the exchange between two or more beings that, however asymmetrical, is never one-sided- as opposed to a one- way direction of effects" (Benjamin, 2006, p. 116.). For Benjamin (2006), intersubjectivity differs from traditional psychoanalytic theory in that it pays attention to the active co-creation of relational patterns by two *active* subjects, not one subject, and one object.

Mitchell addresses this topic and how it theoretically shifts the therapeutic relationship with the recognition that,

The central, enormously impactful shift has been the realization that the analytic relationship is no longer usefully understood as the sterile operating theater Freud believed it could be. The analytic relationship is not as different from other human relationships as Freud wanted it to be. (Mitchell, 2000, p. 125).

Mitchell is getting at the fact that the patient's relationship with his therapist is in many ways, just like a relationship with anyone else; it is not the scientific, objective, relationship Freudian thinkers believed it to be. Relational theory asserts that not only is this shift in understanding the therapeutic dynamic important on a basic level of understanding, but also points out that the "intersubjective engagement between patient and analyst has become increasingly understood as the very fulcrum of and vehicle for the deep characterological change psychoanalysis facilitates" (Mitchell, 2000, p. 125). In other words, relational theorists recognize intersubjectivity in the therapeutic relationship as the catalyst for change in a patient's ways of relating to the world.

From a developmental perspective, the capacity to recognize the subjectivity of others is seen by relational theorists as an important developmental milestone. Not only is it important to see others as subjects (as opposed to objects), it is also important for one to be able to see how someone else views oneself (self in the context of other selves as an object among other objects) (Aron, 1996). In traditional developmental theory it is understood that the child initially has a sense of omnipotence based on his inability to sense how things work around him; when he is hungry, he gets fed by an attentive caregiver and therefore believes that his hunger (or any other desire) controls the world around him- he does not have the capacity to question how or why he was fed. In contrast the eventual capacity to determine one's own influence in the world in a realistic manner is the more advanced ability; even further advanced is the capacity to see others as other subjects in one's environment. An example of this might be the recognition that mother not only is not controlled by the child's hunger, but also has her own hunger. Taking this spectrum of intersubjectivity one step further, Jessica Benjamin posits the idea of the need for "mutual recognition" defined as, "the necessity of recognizing as well as being recognized by the other...it implies that we actually have a need to recognize the other as a separate person who is

like us yet distinct.” (Benjamin, 1988, p.23). Mutual recognition entails “emotional attunement, mutual influence, affective mutuality, sharing states of mind” (qualities often found in both the mother-infant interaction, and the therapeutic relationship) (Benjamin, 1988, p. 16) and requires the recognition that “others are separate but nonetheless share like feelings and intentions” (Benjamin, 1988, p. 53). Though some independence is lost in the recognition that we depend on others so strongly, it is the pleasure of engaging with other “subjects” that is gained in this viewpoint (and omitted in others that do not make note of intersubjectivity) (Benjamin, 1988). Benjamin points out that this also implies that the child “has a need to see the mother, too, as an independent subject, not simply as the ‘external world’ or an adjunct of his ego” (1988, p. 23). This idea is central to the intersubjective view because within it is what she calls the “paradox of recognition”; she writes,

at the very moment of realizing our own independence, we are dependent upon another to recognize it. At the very moment we come to understand the meaning of “I, myself”, we are forced to see the limitations of that self (Benjamin, 1988, p.33),

thereby pointing out that even in what is understood to be “independence” we rely on others. In consideration of this dynamic between mother and child, Benjamin points out that the mother must have her own independent center to be able to fully recognize the child’s independence. This view is a stark contrast to that of the mother as an object of the child’s needs (Benjamin, 1988).

With regards to a therapeutic relationship, the capacity to recognize and to be recognized by other subjects is crucial. The same qualities of introspection and reflective self-awareness that are required to see and be seen by others are useful, even necessary, in therapy (Aron, 1996).



Aron goes so far as to assert that if these qualities are not present in the patient, the goal of the therapist is to help the patient foster these qualities (Aron, 1996, p. 72).

The capacity for mutual recognition of subjectivity also contributes to what relational theorists call the “third space” or in the therapeutic relationship, the “analytic third”. Benjamin defines thirdness as, “The process itself, the relational experiences” (2006, p. 121). The third space, or thirdness in a relationship is the way in which a third way of being is created in a relationship between two people. In a relationship someone can be aware of their own wants and needs (oneness), those of the other (twoness), and finally, can see how both subjectivities can be honored and function together to create a relationship (thirdness). The third space is more than simple complementarity between two people; it is the events that occur simultaneously to create the actual relationship that is the third space. The idea of recognizing individual subjectivity within a relationship speaks to the idea of thirdness between two people. In her article *Two Way Streets* (2006) Benjamin points out to the reader that two points form a line, whereas three create a space between them. In a relationship there is the capacity for not just one person’s ideas or the other person’s ideas; beyond a linear relationship, recognizing each other’s subjectivities opens up the “space” for a collaborative, co-created relationship. Inherent in the concept of thirdness is the idea that failures in relationships “can be addressed, acknowledged and either repaired or mourned” (Benjamin, 2006, p. 120). Within the therapeutic relationship these terms refer to the space (psychic and physical) that is cocreated by therapist and patient to understand, “what is going on between them that reflects the original trauma, conflict, or dilemma” (Berzoff, 2011, p. 230). Taking into consideration each of their subjective contributions to the therapeutic work, the third space allows both therapist and patient to reflect upon it together (Berzoff, 2011, p. 226).

It is clear from the above discussion that relationships and particularly the concept of intersubjectivity are fundamental to relational theory. Relational theory is often described as a “two person” theory. In contrast to traditional one-person theories that have “a monadic theory of the mind”, two person theories of psychology posit “an interactional relational theory of mind” (Aron, 1996, p. 59). Relational and intersubjective theories criticize “the myth of the individual or isolated mind” due to the assertion that such an assumption overvalues artificial individual autonomy that does not give due credit to the effects of others outside of the individual mind (Perrin, 2011, p.139) However, explaining relational theory as a theory concerned solely with external relationships would be misleading. Though relational theory is in fact concerned with ways in which a person interacts with others, the way it is distinct from other theoretical standpoints is that it incorporates *both intrapsychic and interpersonal relationships*. Relational theory separates itself from other theories in that it puts importance on both internal and external relationships, and “real and imagined” relationships (Aron, 1996, p.18). One way that the diversity encompassed within relational theory has been conceptualized and described is as a “relational matrix”. Aron’s (1996) description of Mitchell’s relational matrix gives a straightforward explanation:

The relational approach uses the concept of the relational matrix, the web of relations between self and other, as the overarching framework within which to house all sorts of psychoanalytic concepts. Thus, Mitchell can bring together within one model those theorists, like Winnicott and Kohut, who have emphasized the self; those theorists, like Fairbairn and Klein who have emphasized the object; and those theories, like Bowlby and Sullivan, who have emphasized the interpersonal space between self and other. By elaborating the relational matrix of self and other, Mitchell is able to bring together

concepts from diverse schools, which in many other ways are contradictory and incompatible. (p. 33)

Theoretically relationality is quite eclectic, it pulls from self-psychology, and interpersonal psychology, taking what works in each of these, and bringing more to the table. It is not simply consideration of the self or of relationships that matter, it is consideration of *both* the self, and how the self interacts and comprehends relationships that are important.

To help us further comprehend how these various theoretical understandings of psychological complexity fit into the overarching scheme of relationality, Mitchell conceptualized four “modes”. These four modes, as described below, encompass and establish relationality the idea of relationality. In Mitchell’s own words they are “perspectives on, and accounts of relationality” (2000, p.58). He explicates:

Mode 1 concerns what people actually *do* with each other—nonreflective, presymbolic behavior, the ways in which relational fields are organized around reciprocal influence and mutual regulation. Mode 2 is shared experience of intense affect across permeable boundaries. Mode 3 is experience organized into self-other configurations. Mode 4 is intersubjectivity, the mutual recognition of self-reflective, agentic persons. (Mitchell, 2000, p. 58)

### **Mothering in Relational Theory**

Considering the above concepts and theoretical positions, what role does the mother figure have within relational theory? First and foremost, as is noted in the aforementioned discussion of subjectivity, mothers are seen as subjects in their own right as opposed to the external object that they have been categorized as in traditional theory. Jessica Benjamin describes the issue at length:

No psychological theory has adequately articulated the mother's independent existence. Thus even the accounts of the mother-infant relationship that do consider parental responsiveness always revert to a view of the mother as the baby's vehicle for growth, an object of the baby's needs. The mother is the baby's first object of attachment, and later, the object of desire. She is provider, interlocutor, caregiver, contingent reinforce, significant other, empathic understander, mirror. She is also a secure presence to walk away from, a setter of limits, and optimal frustrator, a shockingly real outside otherness. She is external reality—but she is rarely regarded as another subject with a purpose apart from her existence for her child... Yet the real mother is not simply an object for her child's demands; she is, in fact, another subject whose independent center must be outside her child if she is to grant him the recognition he seeks... The recognition a child seeks is something the mother is able to give only by virtue of her independent identity. Thus self psychology is misleading when it understands the mother's recognition of the child's feelings and accomplishments as maternal mirroring. The mother cannot (and should not) be a mirror; she must not merely reflect back what the child asserts; she must embody something of the not-me; she must be an independent other who responds in her different way. (Benjamin, 1988, p. 23-24)

From this statement we can gather that primarily within a relational framework, the role of the mother is to be her own, unique person external to the child, who responds to her child's needs in her own way. She is more than just the caretaker of her child, she is a person with her own beliefs, values, practices, affect, behaviors; she is her own subject.

The assertion of subjectivity of the mother creates differences in the ways that a child and mother relate to one another in comparison to more traditional psychological theories. Based on

the unavoidable presence of subjectivity in both the child and the mother, the power dynamics of the relationship shift. No longer is the mother seen as being at the will of the child's needs and demands, instead both individuals affect each other significantly. Though they are not necessarily seen as equals and the power between them is very likely asymmetrical (Benjamin, 2006, and Berzoff, 2011) each individual in fact has an effect on the other. This is especially of importance when one considers the traditional understanding of mother in the role of assisting the child with his emotional regulation. Though the mother may help the child to regulate his emotions, her own subjective experiences and affect cannot be ignored in the intersubjective equation. Joan Berzoff explains this idea in her own words:

From birth onward, relational communications take place at a very fast pace between a child and her mother. Not only does the mother impact the baby, the baby impacts the mother. Both engage in a relational dance in which each regulates the other's emotions in verbal and nonverbal ways. The mind, in this view, is not singular but shared so that two minds make up the early relational world of the child. This requires a parent's playfulness, spontaneity, and holding. Communication then is not unidirectional but bidirectional, in that both the infant and caregiver are always engaging in interactive forms of mutual regulation (2011, p. 234)

The mothering role from a relational perspective then is not simply to provide or foster emotion regulation for the child; rather the mother is engaged in the back and forth of *mutual regulation*.

Another implied role of the mother is to engage in mutual recognition with the child. The mother's role in this, based on needing to deal with her own subjective needs and not just those of the child, is a very active one. Whereas other theorists may fail to note the active effort that goes into meeting the needs of the child, Benjamin is quick to point out the "diverse responses

and activities” (1988, p. 22-23) required of the mother to continually engage with the child. Not only is the subjectivity of the mother unavoidable, it is argued that it is of utmost importance in maintaining the health of both the child and the mother; without paying attention to her own subjectivity, the mother might confuse “self-abnegation with recognition of the child’s needs” (Benjamin, 2006, p. 127). This ability to honor both her own and her child’s subjectivity is key in helping the child to feel recognized and creating the third space of the relationship between them. In this context the child experiences his first sense of “mutuality” (Benjamin, 1988). In this vein it can be seen again how it is not only the mother who mediates the emotions of the child, but the child in some ways regulates (or deregulates) emotions of the mother.

Interestingly the importance of the intersubjective relationship and affective attunement between mother and child in early development has been gaining more attention as it has been confirmed by infancy research (Perrin, 2011, p. 141). The ideas of how relationality understands mothering will be discussed further in the next section as they relate to the therapeutic dyad, and Winnicott’s ideas on the “good enough mother”.

### **Relational Theory, Winnicott, and the Good Enough Therapist**

To begin our discussion of parallels between therapists and mothers in a relational framework and in comparison to Winnicott’s thoughts on the good enough mother, we first turn to the words of Joan Berzoff:

In light of Winnicott’s comment about there being no such thing as just a mother but a mother and child as a nursing pair, one might say that from a therapeutic perspective too, there is no such thing as a therapist or a client, only a therapeutic dyad. Again as is true in mothering, both parties in a clinical pair are shaped by one another (2011, p. 225).

And furthermore,

it is not only the mother (read “therapist”) who helps regulate the baby’s feelings but the baby (read “client”) whose subjectivity always influences the mother (therapist). This reminds us that there are never two isolated minds in clinical work, but that there is always an intersubjective field in which the therapist impacts the client and the client impacts the therapist. (Berzoff, 2011, p. 234)

From these statements it is clear that like a mother, a therapist is seen as another subject in a relationship. Just as in the mother-child relationship, each person (both therapist and patient) is understood to affect the other, though always asymmetrically (Berzoff, 2011, and Aron, 1996). In fact transference and countertransference can be seen as ways in which subjectivity is expressed; in the transference and countertransference it is clear how each in the pair feels about and is affected by the other- this is central to relational work. As the therapeutic dyad is made up of two subjects who affect one another, they are engaged in a form of mutual emotional influence. Just as a mother helps the child to formulate and regulate his emotions, the relational therapist, “has to be prepared to try to help put into language what the client cannot.” (Berzoff, 2011, p. 225)

In Benjamin’s (2000) assertion that mothers must be themselves, have their own subjectivities in order to help their child develop his/her own subjectivity, and that they should not solely be a mirror of the child’s feelings there is an argument for subjectivity in therapy. The therapist (mother) must not simply reflect back to the patient as a mirror, but acknowledge from her own subjectivity, and the subjectivity of the patient. To clarify the difference here, consider the two psychotherapeutic interventions of mirroring, and validation. Though mirroring reflects that a therapist has heard the patient, validation indicates that the therapist has both heard, and on some level recognizes the experience of the patient. This interpersonal recognition in the form of

validation is what relational theorists understand to be of utmost importance in the therapeutic relationship.

Further argument for recognition of the subjectivities of mother and child, therapist and patient, comes from Aron's point that usually the child/patient deliberately seeks out the subjectivity of the mother/therapist. He writes,

Patients seek to connect to their analysts, to know them, to probe beneath their professional façade, and to reach their psychic centers much in the same way that children seek to connect to and penetrate their parent's inner worlds. The exploration of the patient's experience of the analyst's subjectivity represents one underemphasized aspect of the analysis of transference, and it is an essential aspect of a detailed and thorough explication and articulation of the therapeutic relationship. (Aron, 1991, p.29-30)

From his point of view, subjectivity is an innately appealing, significant, apparent and too oft ignored piece of the therapeutic relationship.

The relational views of subjectivity within mother-child and therapist-patient dyads add levels of complexity to Winnicott's ideas about the good enough mother. Take for instance the idea of the primary maternal occupation. Winnicott postulated that the primary maternal occupation is a temporary ability unique to mothers (or primary caregivers) that allows them to put their own needs on hold in order to meet those of the child, especially in infancy and early childhood (Winnicott, 2002). Due to the primary maternal occupation the mother identifies more with the child than others might, and in essence has her focus entirely on the child. Winnicott viewed this as healthy and normal. From a relational perspective the idea of putting one's subjectivity entirely to the side is an inaccurate assessment of the situation. Relational thinkers



would agree that the mother (or therapist) can foster a close attunement with the child (or patient) and can even give the child's needs some priority over her own, but the idea that the mother's subjective needs simply disappear in the presence of the child is one that relational theorists protest. Lacan, as cited by Benjamin (2004), argues that should the needs of the mother merge with those of the child in such a way that maternal subjectivity was foregone "then mother could nurse unstintingly in total identification with baby, but there would be nothing to stop her, when she was starving, from...eating the baby" (p.13). Though this is an extreme portrayal of the situation, the example makes it quite clear that the ability of the mother to hold both the needs of the child and her own is indicative of presence of the "third" and inarguably the presence of the mother's subjectivity (i.e. the mother's hunger). Neither a therapist's nor a mother's subjectivity will ever completely dissipate. Additionally relational theorists would likely support the idea that the primary maternal occupation is not a given that happens to all mothers automatically, but rather that mothers have subjective and individual choice in how they choose to respond to their children.

Relational theorists make a similar argument in regards to Winnicott's idea of the mother or therapist as creator of a "holding environment". The thought of reducing a subjective external being (mother or therapist) simply to a container or object to hold the child's or patient's difficult emotions is one that relational thinking takes issue with. Lew Aron explains the danger of denying therapist and maternal subjectivity in this context:

The metaphors of the analyst as "good enough mother" and "holder" (Winnicott, 1986) or as "container" (Bion, 1970)...of the patient's pathological contents have been extremely useful inasmuch as they have drawn attention to nonverbal and subtle exchanges and to the ways in which the analyst needs to respond to these "primitive communications". The

danger with these metaphors, however, is not only that the patient may be infantilized and deprived of a richer and more complex adult kind of intimacy...but that the analyst is similarly instrumentalized and denied subjective existence. Instead of being seen as subjects, the mother and the analyst are transformed into the baby's and the patient's "thinking apparatus" (Bion, 1970). (1991, p. 32).

The danger then is to reduce the subjectivity and effort of the therapist or mother into little more than a mechanism in service of the patient or child. That being said, relational thinkers do continue to recognize the potential of the therapist to act as a container for the patient's relational communications. Berzoff points out, "Very often, the practitioner may unconsciously find herself holding, feeling, and having to bear her client's disavowed thoughts and feelings" (2011, p. 224). Relationally it is understood that communications to be held are made through projective identifications in which the therapist or mother is able to experience or feel the experience of the patient or child through their interactions with one another (Berzoff, 2011). External subjectivity of the therapist also brings a new element into the idea of "holding" in that each therapist creates a unique holding experience with her unique client; the holding experience is the product of intersubjective interaction. This is in contrast to a Winnicottian unidirectional holding experience where the holding is determined directly by the needs of the patient, disregarding the actual subjective holding capacity of the therapist.

Whereas Winnicott saw the transformative power in the act of psychological and physical holding, relational theory also differs in that the healing power is in the maternal or therapeutic relationship itself. What unites relational theorists is their belief in the reparative quality of the therapeutic relationship (Greenberg and Cheselka, 1995). Despite differences in relational theories, "Running through... various formulations is the belief that being in therapy is a new

interpersonal experience for the patient. The quality of this experience ... profoundly influences the outcome of treatment.” (Greenberg and Cheselka, 1995, p. 57)

Considering that from the relational view the mother/therapist is not a need-gratifying object but instead engages in a meaningful relationship and identification with the other, this takes some of the element of right and wrong or “good enough” or “not good enough” element out of the therapeutic and mothering relationships. It becomes not so much about exactly what is done, but the communication and affect that is shared between the two (whether mother and child or therapist and patient). Spencer makes note of how this sentiment is shared throughout relational thinkers,

Psychological healing is understood to occur within the context of mutual and empathic relationships (Aron, 1996). For Mitchell (1993), what the analyst does is not as important as how he or she does it...It is in the context of a responsive and co-constructed relationship, where the analyst and analysand together work to deepen their understanding of the meaning of the analysand’s experiences, that psychological change occurs. (Spencer, 2000, p. 10)

Given this argument it is important to consider Stolorow (1994) who points out that trying to decipher whether interpretation or intersubjective connection provides the healing mechanism, is a false dichotomy. He highlights the fact that an interpretation, without the accuracy gained from affective bonding between the therapist and patient, would be ineffective; analyst’s attunement with the patient is crucial in being able to make a holding interpretation in the first place (Stolorow, 1994).

The final comparison between Winnicott’s “good enough” parenting and relational therapy comes from the question of what the aim of good parenting or therapy is. Whereas

Winnicott would argue for moving toward separation and independence via facilitating development and releasing developmental hold ups, relational thinkers posit individual psychological health in terms of “a sense of subjectivity and agency, in the context of relatedness and recognition by, and identification with, a mother (analyst) who is a subject in her own right.” (Mitchell, 2000, p. 65-66). One take on this is Mitchell’s “relational-conflict approach”. Mitchell, as cited by Aron (1996), pointed out that Winnicottian formulations of developmental deficit or arrest take the element of subjectivity and internal conflict out of the equation in terms of individual development. By refocusing on internal conflict and relational conflict as opposed to relational-deficit, the individual is removed from the position of passive victim of his not-good-enough childhood and is restored some personal agency (Aron, 1996, p. 34). In this formulation the therapist is no longer in the role of re-parenting but is meant to engage with the patient in a way that increases his capacity create and participate in healthy relationships. This is in line with the relational goal of working toward capacity for relationships and mutual recognition as opposed to fostering autonomy.

## CHAPTER VI

### Discussion

#### The Case of Pearl

To begin our discussion of overlap between the three schools of thought presented in previous chapters, we now turn to the case of Pearl Quincey, a case presented by Deborah Luepnitz in her book, *Schopenhauer's Porcupines: Intimacy and It's Dilemmas: Five Stories of Psychotherapy* (2003). The case has been chosen for it's prominent maternal themes in the transference and countertransference and its ability to illuminate the theories discussed thus far. The case material will be briefly explained, and then examined through the lenses of Winnicottian thought, attachment theory, and relational theory. This exercise is meant to illuminate the ways in which these theories overlap and emphasize the power of the human connection. For a more detailed understanding of the case of Pearl, it is suggested that the reader refer to the original work.

Pearl Quincey is middle-aged Jamaican-born woman. She was born in a Jamaican shantytown to a teenage mother. Along with her mother, she moved to the United States at a young age. Shortly after arriving in the United States Pearl's mother Rita became involved with a man whom she eventually married. This man became Pearl's stepfather. Her stepfather was an alcoholic who was often physically violent toward his own sons, Pearl's stepbrothers. Following her younger sister's accidental death, Pearl, at the age of fourteen, returned to Jamaica to live with her aunt at her mother's insistence that she focus on her education. She was relieved at the

chance to return to Jamaica, as she feared her stepfather, and had been blamed by him for her younger sister's death. From a young age Pearl greatly admired her mother. Pearl was (and still is) quick to please her mother, and is pained by the victimization she witnesses her mother suffering at the hands of her stepfather. She vows never to let herself become the victim of a man. Pearl, upon returning to Jamaica is intent on becoming greatly successful in order to prove her stepfather's predictions of her demise into promiscuity as wrong. Fortunately Pearl feels "deeply understood" by the schoolteacher aunt she goes to live with, and they foster a close relationship.

As she matures, her teachers recognize Pearl's brilliant intellect. With their encouragement, Pearl pursues higher education and eventually a career in academia. Both in her childhood, and in her educational path, she faces racism as a woman of color. She works furiously to support herself and her family along the way, sparing little time for enjoyment. She eventually obtains a position as an assistant professor of literature at a prestigious American university. However, after years of hard work and her dream of professorship coming to fruition, Pearl finds herself to be "less stimulated, more isolated, and depleted than ever before". Rejection of her attempt to secure tenure leads Pearl to her breaking point. She enters therapy shortly thereafter when the aforementioned rejection triggers a bout of sciatica and she can hardly move. Pearl reports ruminating on negative thoughts, mostly around her career. She has insomnia, is tearful and anxious. She is depressed.

Upon entering therapy Pearl describes herself as "fiercely independent". She has always been "too fiendishly busy" for therapy leading up to this point, and believes therapy to be self-indulgent. If not for feeling "shipwrecked" it is likely she would have never come. Not having a sense of herself anymore also motivates her to begin therapy: she states, "I come from a line of

strong women, and I have never broken down. I can't recognize myself in the fragile mess you see before you." Pearl has other hesitations in beginning therapy, specifically a fear of devaluing or discrediting her family. She says to her therapist, "My mother is my closest confidant. In therapy, one delves into the family to pick it apart, and that would not be helpful to me. I need you to help me with the present, not the past."

Though her outright hesitance to discuss her past provides a challenge to the therapist Deborah, Deborah, is immediately drawn to Pearl and feels that they have a connection. Though their sociocultural backgrounds do not have much in common, the therapist, from her point of view, identifies a felt "kinship" between herself and Pearl. The therapist experiences Pearl as highly intellectual, captivating, physically striking and beautiful. She is puzzled as to how such a talented, intelligent and impressive woman can possibly be suffering at the depths she is suffering.

Early on in therapy Pearl likens herself to a "Darwinian finch" on the grounds that these famously studied birds, though they look strikingly similar to one another, are actually different species that do not mate between species. Like these birds Pearl feels as though she is fundamentally different than her peers (especially in her professional world); she feels undateable, and unmateable. Though she may look like anyone else on the outside, she believes her insides make her different. However, for the most part she is content with this. She has accepted her core difference and reveals to the therapist that she has never been partnered or married, and has no children. In fact, she prefers things this way. This theme of untouchable uniqueness and difference later becomes prominent in the therapy.

Often in the first year of therapy Pearl uses her sessions to describe her struggles with her job as a professor, with the racism and sexism she faces by colleagues, and the distress she has in

being unhappy in a position she has worked so hard to attain. Her therapist senses that Pearl above all else needed to be heard, to be listened to. Pearl reflects on a quote from a novel that resonates with her: “the sound of my own voice had always been a calming potion to me”- she begins to value the opportunity to hear herself in therapy, what her therapist identified as “the relief of speaking in front of the other, of being heard”. Her therapist also recognizes within Pearl what she refers to as “the manic defense”; the tendency to put her efforts into projects and worries outside herself, continually distracting away from her own needs. Pearl shares that her childhood nickname was “Little Mama”; it is she whom everyone always looked to for strength. Particularly in light of the racism and sexism she continually faced, and not getting recognition she deserved at work or in her family, Deborah wants to discuss Pearl’s need for recognition. Pearl is not excited about this. She says that she does not want to, “Not because you’re wrong, but because I don’t fancy the idea of needing validation from others. Remember, I’m usually the one who ladles it out”. This indicates the degree of Pearl’s independence; she was hesitant to accept even validation from others. Her stories often focus on criticisms she received, and only with pressing does the therapist reveal that Pearl does in fact receive compliments at times (which Pearl dismisses as insincere).

As the therapy progresses the relationship between Pearl and her therapist becomes closer. Pearl finds herself counting the days in between weekly sessions and developing, what she feels to be an unfamiliar, uncomfortable and unsettling “dependence” on the therapist. In the therapy this new feeling of “dependence” is explored and normalized. Pearl is reminded by her therapist that their relationship is only temporary and that the dependence will not last forever.

Both Pearl and her therapist come to note a maternal quality in the transference. Her therapist feels herself desiring to be Pearl’s “closest confidante”, the way Pearl first describes her



mother. The therapist finds herself “enraged on her behalf and wanting to defend her” when hearing of Pearl’s trials and tribulations. Pearl shares with Deborah, “You can be almost as comforting as my mother. I used to say my mother would have made a great lawyer, but now I think she should have been a therapist”. This statement highlights the admiration and closeness that, once reserved only for her mother, Pearl now feels for her therapist. Furthermore Pearl identifies her therapist as being “like the women in my family”; surely a statement about the comfort, soothing, and strength she finds in her therapist. The therapist notes that Pearl has been in a helping, parental role herself, which likely makes it more difficult for her to accept help for herself. In her writing on the case Deborah reflects, “I hoped Pearl would someday be able to lean on others, starting with me”. With increasing ease, Pearl learns to utilize her therapist as a support.

As the therapy progresses the work becomes deeper. Over time Pearl feels safe enough to share more about her family and her past; she no longer experiences the relationship with her therapist as a threat to the integrity of her family; rather, it seems from the way Pearl describes her feelings about Deborah, Deborah has become like a family member, perhaps even a mother-figure. Eventually, they focus their work on Pearl’s sense of herself as different and unique in such a way that it has maintained her solitude throughout her life. Partially due to the discovery that the exclusive mating patterns of Darwinian finches are nothing more than popular legend, Pearl finally feels free enough to explore the possibility of pursuing intimacy and relationships. The therapist recognizes that Pearl is seeking her approval; she writes,

Pearl wanted reassurance that I could tolerate her becoming sexually active. Her parents had managed to foreclose her curiosity and experimentation. Pearl wanted to make sure I would not be put out, frightened, censorious, or jealous of her new adventures.

With support and guidance from her therapist, Pearl successfully begins dating and eventually becomes happily involved in a long-term, serious relationship.

The theme of Pearl's desire to be perfect arises in the therapy; with insight, Pearl relates this to her mother's love. Her therapist writes,

She had lived to be her mother's perfect daughter, thereby vindicating Rita's life of sacrifice. Pearl was beginning to glimpse the error in this: There were no perfect daughters; and showing weakness, admitting to desire, were not decisions taken against her mother.

As she finds more comfort and confidence in her own identities, and more familiarity with the idea that she will not be perfect, Pearl begins to utilize therapy less often. She begins cancelling sessions unexpectedly. Reflecting on Pearl's newfound disregard of therapy, and the therapist's own avoidance in addressing the repeated cancellations, Deborah writes, "I believed we were reenacting the relationship she had with her mother, in which clear boundaries were sacrificed and conflict foreclosed by the wish to be close and unique to the other." Eventually, and very importantly, the therapy openly addresses Pearl's experience of the therapeutic relationship and the feelings underlying Pearl's repeated cancellations. Additionally Deborah, a white woman, is thoughtful about her own internalized racism, the differences in her and Pearl's upbringings, and socioeconomic backgrounds, and how these variables have been affecting their relationship.

Meanwhile Pearl's relationship with her mother changes as well. Instead of once daily phone calls, Pearl begins speaking with her mother only once per week, and requests help from her siblings in sharing some of the responsibilities in caring for their mother. They remain close but must re-navigate their relationship especially in regards to Pearl's new romantic relationship. She works to create new boundaries with her mother. Additionally Pearl pursues and accepts a

new job at a different university that she feels will be more fulfilling. She begins to consider the possibility of becoming a mother with her partner Joshua, a possibility she had never contemplated before. By the end of three years in therapy, her life and ways in which she is connected to others had changed drastically.

Like any therapeutic encounter, the end of therapy does not necessarily mean that Pearl went on to live happily ever after. With any psychotherapy patient, therapists usually do not know what comes of the patients and this case is no different. That being said, Pearl's journey through therapy provides a wonderful lens through which to examine the theories discussed up until this point.

In a Winnicottian frame, the therapist successfully provided a skeptical Pearl with a satisfactory holding environment. Though doubting and fearful of the intimacy and "dependency" of therapy at first, Pearl eventually relaxed into it and became comfortable using the therapist as a regulator of her emotions. She brought her emotional struggles into therapy seeking the therapists' support (yet often solving her own dilemmas by simply hearing herself speak out loud, using Deborah as a sounding board). If needed, she called between sessions. Continually the therapist was present to regulate, reflect, support. Like a mother would, she helped Pearl in identifying, articulating, and observing her emotions. In her own presentation of the case, Deborah wrote about her initial attempts at validating Pearl's experience as "impingements" from Pearl's point of view. She writes about how initially validation felt unwelcome to Pearl; Deborah was able to recognize the importance of simply hearing Pearl to provide the holding she needed. In this way, and in others, the therapist was "good enough" in that she recognized Pearl as separate from herself, and with her own needs; despite the kinship and connection she felt with Pearl, she was able to recognize Pearl as an "other", put her own

needs on hold (much like the primary maternal occupation), and meet those of the patient (child). In a very specific way, in line with Winnicott's definition of holding in therapy as revisiting a point in development when holding was unsuccessful the first time around, the therapist successfully "held" Pearl in her readdressing the development of her intimate, romantic, and sexual identities, aspects of her identity development that had been silenced in her youth. The therapist provided a space for identity development that had not been good enough the first time around. Parallel to a child's development, Pearl initially utilized therapy (the mother) often early on for meeting her natural "dependency" needs; as she grew more confident, more emotionally adept and mature, Pearl's "dependency" decreased to the point where she felt ready to leave therapy.

Much too can be said about the attachment developed between Pearl and her therapist. Pearl entered therapy as a solitary individual, for the most part. With the exception of her mother whom she was enmeshed with, Pearl avoided emotional intimacy to the point of being celibate for her entire adult life. One could describe her attachment style as dismissing. She was both avoidant of intimacy and counter-dependent, preferring not to risk depending on others to meet her emotional needs. Furthermore, she expressed contentment in this solitary lifestyle. It can be hypothesized that likely, this attachment style was learned beginning in her childhood. She had witnessed the violence against her mother and resolved to never become a man's victim. Moreover experiences of racism likely led her to the same conclusion: if I don't need support from anyone, I can't get hurt. This explains the development of her dismissing attachment style, and also her hardworking and perfectionist, tendencies. If nothing else Pearl was determined to be hardworking and prepared. The therapist noted what she believed to be a reenactment of Pearl's relationship with her mother in the transference; as supported by attachment theory, early

attachment styles often serve as a model for how one interacts with others- therapists are not an exception to this rule. Pearl's new relationship with the therapist was regenerative. Her therapist wrote eloquently, "I hoped Pearl would someday be able to lean on others, starting with me". This desire reflects the ability for changing attachment just as Bowlby describes it; a new and different secure relationship can change the possibilities of future attachments. The therapist's yearning came to fruition. Through their work Pearl developed the capacity to relate to others in manner that was novel to her. She slowly navigated the process of building trust and intimacy with someone outside her family in a way she had not done before. In the original case conceptualization the therapist writes,

Pearl practiced some distancing moves on me. She, who had never cancelled a session without good reason—and certainly without notice—was now cancelling frequently...She seemed surprised to learn that I was not irritated with her, and that I was no less pleased to see her the following week. This helped her to understand that getting angry with close friends, with Joshua, and maybe even with her mother might be possible.

The above quote exemplifies how Pearl and her therapist engaged in attachment and caregiving behaviors; for example, when Pearl withdrew, her therapist extended an invitation to return. The relationship with her therapist was protective and served as a model for her to begin developing new relationships. The relationship template co-created by Pearl and her therapist was extended by Pearl into several aspects of her life. Notably Pearl began a romantic relationship and also shifted the dynamics between herself and her mother in a healthier direction.

Finally we look at the case of Pearl through a relational lens. The role of the relational theory in this case is seen clearly in discussion of Benjamin's idea of recognition, discussed in

the previous chapter. Deborah identified Pearl's need to be heard, the need for Pearl's subjectivity to be recognized as it had been hidden for so long. Both parties discussed their own subjectivities. The therapist was thoughtful about the differences in their subjective experiences and identities, particularly in regards to culture and race. Despite individual differences, the intersubjectivity established between them- the relationship itself, proved transformational for Pearl. Much like the new attachment style described above, the intersubjective relationship that was developed, gave Pearl an experience she had never had anywhere else. The author's reflection on this topic can be read below:

She let me know that she had experienced “zero” recognition from her stepfather, but that she had been “loved and adored” by her mother and “deeply understood” by her aunt. We agreed that she needed to learn to accept recognition from people outside of the family and particularly, it seemed, from male colleagues. I believed, moreover, that there were aspects of Pearl – her sexuality and desirability, for example – that had yet to be reflected convincingly by anyone. It was in this session that I asked Pearl if she felt recognized by me. “I do. To a surprising degree”.

This passage makes clear the degree to which Pearl was able to accept recognition from her therapist. As the therapist recognized Pearl's subjectivity, Pearl recognized the subjectivity of her therapist. She mused about wanting to know details of the therapist's life but rejected the chance to actually know details of Deborah's life for fear of being drawn to needing to take care of her; she recognized and respected differences between them, and took the differences into account in creating their relationship.

Underscoring the importance of recognition, it is when Pearl finally feels as though her story is not captured by the mythical isolated Darwinian finch that her interest and ability in

creating relationship blossoms. It is when she can be seen for who she is, when she is recognized as not only a successful intelligent professor, but also a human with emotional needs and desires, that her relationships have the freedom to shift.

In each of the three theoretical frameworks, Pearl's connection with therapist serves to model connection with others. Her relationship with the therapist also provides a place for regulation/holding/recognition. Each theory highlights a different aspect of the relationship; importantly each theory *is about relationship*. For Winnicott, relationship creates an emotional space. Similarly, in attachment theory, a protective emotional space is created (in a secure attachment). In relational theory, the unique identities and interactions of two individuals create an emotional space within a relationship. Based on this it seems evident that the common thread uniting these three theories is connection, relationship.

### **Findings and Discussion**

In considering how Winnicott's ideas on child development and good enough mothering line up with both attachment theory and relational theory, we will now take the time to reflect on common findings between the theories.

First and foremost, what seems particularly important are the protective and facilitating factors of the mothering relationship. In the mother-child relationship, the connection with the mother is perceived by all theoretical positions to have protective, holding (physical and emotional), and regulatory (physical and emotional) qualities for the child/patient. As Winnicott pointed out, the mother, and similarly the therapist, are in the position to help the child or patient navigate their way through new emotional territory as a vulnerable being. Attachment theory too is explicit about the importance of the protective role of the mother or primary attachment figure. In relational theory, though it takes a different approach where the therapist is less explicitly

protective, the therapist is seen as someone who can help the patient tolerate, and regulate emotionally in the face of great distress. Whether using Winnicott's language of a "holding environment", discussing Bowlby's sense of biological protection given by the attachment figure, or taking the relational perspective of a the therapist as a receiver and contributor of relational communications, the sense of protection and regulation is largely present.

The other clear message from the comparisons of these theories is the irreplaceable importance of relationship, of human connection. Many psychological theorists, and everyday parents come up against the challenge of defining good-enough parenting repeatedly. The intersection of these theories highlights that *it is the quality of connection between parent and child itself that is the significant part*. Though Winnicott's initial postulations do not give as much thought to the details of how an individual's behavior affects another (for example, he discusses "impingements" into a child's development but does not spend much time discussing what these might be), the parallel discussions of Bowlby's attachment and careseeking behaviors, of attachment styles, and the relational discussion of subjectivity and intersubjectivity lead us to believe in the power of connection. As Winnicott pointed out, there is no such thing as a baby without a mother; Berzoff (2011) followed this with the recognition that there is no such thing as a patient without a therapist; *we exist only in connection with one another*. The beauty of this approach is that there is room for individual differences within it- the importance of subjectivity whether mother or child, therapist or patient, means that no matter who we are, what we do, or what issues we face, we universally need connection to another. This flexibility, found through the consideration of subjective choice and desire, is perhaps what Winnicott was referring to with his choice of the phrase "good enough". He was wise to know that there is not a one-size-fits-all equation that could determine successful human connection or child



development, but it was clear to him that the relationship itself (and in turn its inherent regulatory and protective properties) is what must be “good enough” to support healthy development.

The writing of Ruth Sterlin (2006) supports the notion of the importance of connection as the interaction between attachment theory and relational theory in therapeutic work. In discussing two clinical examples from her own work Sterlin asserts that the therapeutic relationship, a “real, two-person relationship” (2006, p. 165) is therapeutic based on its ability to form a “real attachment” between two subjective people that allows the patient to “look around at our [the therapist’s] inner world” (insertion added, 2006, p.173). As she eloquently points out, mutuality is “the signature of an attachment” (Sterlin, 2006, p.169). Only through the power of connection can a fellow human provide the chance for a patient (or child) to be soothed by her own presence, words, contributions and experiences.

Thinking about the flexibility of technique and mode allowed by the “good enough” model of connection, there are further comparisons to be made. Mothering is a natural process that many would argue comes instinctually in many respects. Despite thousands of attempts by people around the world to contribute their knowledge of good mothering in writing and through oral tradition, there is no universal handbook on mothering. Similarly therapy takes many shapes and forms. A multitude of practices and theories contribute to how therapists choose to practice therapy; like mothering, there is no one “right way” of doing therapy yet all center around one thing; connection with the therapist. Even when there is not the chance to develop a deep individual connection with a therapist, such as in group therapy, there is opportunity to connect with others in the group. Likewise, in cultures worldwide, connection between parent and child is highly valued; in no cultures are children left to raise themselves. Thinking about cultural

difference in family structure and specifically how one is a successful mother, the good enough model maintains plenty of space for cultural variation in child-rearing practices. Such variance between cultures in child-rearing and parenting can be seen in the work of Fred Rothbaum and Natalie Rusk (2011) who looked at differences in child-rearing goals and strategies between European-American and East Asian cultures. Strikingly they identified two distinct pathways toward emotion regulation, independent and interdependent. Though they did not assert that one is superior to the other, their work highlights just how diverse parenting practices can be within the human species. From my perspective, the universality of the success of connection while making room for cultural difference makes the overlap of Winnicott's ideas, attachment theory, and relational theory both influential and powerful.

Interestingly, though the idea that human connection is central to successful emotional development through the many lenses we have examined, there is one historically significant dimension that is not weighed heavily within these models. Traditionally, the role of the unconscious in both child development and many theories supporting psychoanalysis has been nothing less than central. It is of note that by putting focus on connection with a regulatory, dependable, holding person, the role of the unconscious appears to be less important than ever before in these theoretical applications. Granted, the role of the unconscious is not entirely absent (particularly in relational theory as it takes into consideration intrapsychic events) but it is clearly given less attention and thereby less importance. Moving forward as developmental, psychological, and psychotherapeutic theories continue to evolve, it will be important to monitor the status of the role of unconscious. Though it seems unlikely that it's role will ever diminish entirely, the preceding analysis of theory indicates that the unconscious may be losing clout in modern formulations of psychological well-being.

In pondering what else these theories leave to be desired, it is of interest to note that though they present a coherent and rather well rounded picture when combined, individually, the theories we have examined are less comprehensive. In addition to the general lack of addressing the unconscious, the theories each standing on their own cannot completely explain a person and their relationships in their entirety. None of the theories on their own explain every aspect of child development, human motivation, personality and individuality development, along with social and relational tendencies. This critique does not mean to accuse these theories of lacking more than others; for it is an extraordinary feat for any theory to be able to explain any and all phenomena, especially in the unpredictable and imprecise science of human beings. That being said, it is clear that each theory has its limitations. For example, though Winnicott thoroughly describes what is necessary for good enough care, the theory fails to capture the essence of the relationship or bond itself. Additionally the mother is portrayed as an external object to the child, which, in light of the concepts discussed in relational theory, we can see is largely inaccurate. Though we come away with an understanding of whether care has been good enough, Winnicott does not say about the individual person.

Attachment theory leaves us with similar questions. Attachment theory clearly describes the relationship characteristics, motivation for human connection and the roles and behaviors of each person in creating the relationship, but fails to account for the individuality and uniqueness that come along with each human pair. Granted, there is variation between patterns of attachment style (that have been expanded upon in decades following Bowlby's pioneering work) but does the theory simply understand those in matching attachment categories to be similar all around? It is likely that Bowlby would answer this question with a resounding "no" however the lack of detail regarding individual difference demonstrates where there is a hole in the theory. Though

his intent to use scientific observation of animal behavior to compose his theories was noble, the result has been that Bowlby's attachment theory lacks characteristics that fully represent the human experience.

I would argue that of the three theories discussed, relational theory is more comprehensive than the previous two in many ways; however it too is imperfect. Though it's discussion of subjectivity and intersubjectivity allows for much flexibility in culture, experience, and generally unique individual attributes of humans, as noted in the previous chapter, relational theory features the conspicuous absence of ideas on child development. It seems that, by taking into consideration the strengths and weaknesses of each theory respectively, the best method in understanding a person's development and psychology (and psychopathology) should include analysis through all three theoretical lenses.

The case of Pearl can be used to justify the argument for combining the theories. Should Pearl be discussed purely in Winnicottian terms we would have a detailed explanation of her upbringing and the ways in which her needs were met or not, but lack a full vision of Pearl as she exists as a mature woman. Perhaps she was held in certain ways, and not in others, but we would be left to wonder how her adult experiences of racism and sexism contributed to her current struggles. Attachment theory would similarly focus on her relationship patterns, for better or worse. Attachment theory effortlessly identifies Pearl's problematic dismissing attachment style, but leaves her with no applicable advice beyond instruction to just make new, better connections. The details of her life and personality are not calculated into the equation, other than to note how early relationships may have played a role in defining her current patterns. Though relational theory would more adeptly explore Pearl as an independent, thoughtful, intellectual woman, who is a product of her culture and social system, a purely relational approach would not necessarily

look at Pearl's upbringing, which is arguably essential to understanding how she came to be the woman she is. Though concepts from each theory can be fluidly applied to the case of Pearl, the fact remains that we need all of them to appreciate the many facets of Pearl.

Each of these theories has their focus on relationship as the connecting thread; this unites them. However a closer look exposes large differences between them. For these reasons, it seems that the most comprehensive understandings can be gleaned from the combination of all three theoretical standpoints. As can be seen from the explanation above, these theories truly complement and supplement one another. With Winnicott we get the perspective of early development, with attachment theory, the focus on protective and facilitating relationship that carries into adulthood. Relational theory includes individuality (subjectivity) with consideration of both internal and external events, and alongside attachment theory, carries the description of the human experience throughout adulthood. Utilizing the diversity provided by all three theoretical lenses, the human life span and scope of experience is covered much more comprehensively. Thinking in terms of applying theory in a therapeutic situation, a therapist would be much better served by the strengths of Winnicottian, attachment, and relational theories rather than sticking with only one to guide her practice.

### **Considerations of Culture and Gender**

To make a thorough analysis of the topics covered thus far, it is important to consider the cultural context of these theories and how they were established. Based on considerations of the time, politics, personal identities and locations affecting the creation of these theories, can they be seen as applicable or relevant today? The British Psycho-Analytical society of which Winnicott was a part was composed of twenty-six members, only six of them women (Rodman, 2003). Their group, in contrast to the other European Jewish psychoanalytic groups of the time

was “primarily Anglo-Saxon” (Rodman, 2003, p. 5). Issroff, (2005) speaking of the work of Winnicott and Bowlby points out, “It should be remembered that both Bowlby and Winnicott were born before women had the right to higher education or the vote, and the rights of children were not yet on the agenda” (P. 160). Looking at these statistics, Winnicott a white male surrounded and influenced academically primarily by other privileged white males, seems an unlikely expert on the topic of mothering and child development. In fact, since the time Winnicott lived women around the world have gained the right to vote, and even children’s rights are a prominent political topic. To say that his understandings of mothering (which are based on his own childhood experiences and his work as a clinician) would seamlessly transition into the modern world would be a stretch. But there are aspects that continue to hold their validity in a strong way.

So after all of these years, do his theories hold true? Are they culturally relevant in the US? Are they culturally relevant around the world? Though the topic of worldwide cultural relevance is beyond the scope of this paper, it can be safely argued that the key elements underlying Winnicott’s ideas, and those shared with attachment and relational theory, seem to carry significance in many ways into the modern world. Though details of Winnicott’s understanding of how women operate in daily life as mothers may be outdated because he necessarily hypothesized based on the conventional beliefs and practices of his time, his general message that connection and support provided by mothers and therapists is crucial in emotional regulation and development continues to be valuable and relevant to both child development and psychotherapy. Politically, technologically, socially, the world has changed, and continues to change but the human need for connection persists.

Talking about the ways in which the world has changed brings the opportunity to discuss the unique role women have been given in the mothering/therapy parallel, and how families have changed (or rather how varying family structures have been given more recognition) over time. To his credit, Winnicott did recognize that his identity as male made him an outsider when speaking about motherhood. The first chapter of his book *The Child, the Family, and the Outside World* is entitled “A Man Looks at Motherhood”. He addresses the reader saying,

To begin with you will be relieved to know that I am not going to be telling you what to do. I am a man, and so I can never really know what it is like to see wrapped up over there in the cot a bit of my own self...only a woman can experience this.

(Winnicott, 1964, p. 15).

Though this recognition is somewhat comforting, it does not remove the fact that Winnicott speaks about the role of women from an outsider’s position. As Winnicott and Bowlby were living and writing before feminism was strongly and widely supported it can be argued that their focus on mothers as primary and ideal caregivers (as opposed to parents or fathers specifically) is likely principally a reflection of the times when men were seen to have roles primarily outside of the home, and women usually stayed home to raise children. Contemporarily in modern Western societies, now that families continue to break and redefine these roles, is there something that continues to hold the mother in a superior caregiving position over a father? Despite continually evolving progress in terms of gender equality both legally and socially, even recent psychoanalytic literature persists in discussing both mothering and female therapists in the context of mothering roles as special in some way. Inarguably women have physical experiences that men simply do not during pregnancy and mothering. However, it is likely that gender

stereotypes and accepted social norms of women as more nurturing, emotional, and sensitive continue to perpetuate the view that women are somehow superior in this way.

Winnicott (1988, p. 112) made his view clear that the biological mother is the preferred caregiver for a child; he writes,

To some extent it is true that the needs of an infant can be supplied by anyone who loves the infant, but there are two sets of reasons why the mother is the right person. Her love of her own infant is likely to be more true, less sentimental, than that of any substitute; an extreme adaptation to the infant's needs can be made by the real mother without resentment. The actual mother will be able to continue with all her little details of personal technique, thus providing the infant with a simplified emotional (which includes physical) environment. A baby that is beautifully cared for by several different people, or even by two, has a much more complex beginning to life, a much less sure background of things to be taken for granted when desires appear as complications from within. A good deal of confusion can arise out of neglect of this consideration. It is true, as Anna Freud points out, that techniques are the important things that affect the baby at the beginning. But simplicity and continuity of technique can only be given by one person who is acting naturally; and no one but the mother is likely to be able to supply this, unless it be a suitable adoptive mother taking over care from the very beginning. But the adoptive mother usually lacks the real mother's orientation to motherhood, or special state that needs the full preparatory period of nine months.

Though it is clear that Winnicott is thoughtful in these considerations, changes in family structures and how both women and men approach parenting roles has shifted drastically since the time that Winnicott first wrote these words.



As Issroff (2005) noted, since these times, women's rights and access to higher education have been granted and the overall conversation of gender equality has become much more vigorous. In many ways these changes bring to light some inconsistencies between how Winnicott thought, and our world today. For example, Winnicott argues that adoptive parents lack the "special state that needs the full preparatory period of nine months"; I would argue that with the intense and lengthy application and legal processes, along with the financial requirements entailed in modern formal adoptions, some adoptive parents may be more prepared in many ways than natural parents who conceive a child unexpectedly. Additionally adoption and legal guardianship are much more legally complex and involved than in Winnicott's time. This makes for fewer chances for resentment on the part of adoptive parents, as adoptive parents are very seldom put in the place of caregiver by chance. I presume that in contrast to the "resentment" Winnicott imagined, an adoptive parent who is unable to conceive naturally is likely grateful for the chance to raise a child and not at all resentful of the child any more than a biological parent would be.

Additionally, I take issue with the portion of Winnicott's above quote that refers to the complications arising from caregiving by several different people. Considering the many cultures that raise children in multi-generational households, or in more complex family structures than the traditional nuclear family Winnicott would have been most familiar with, it seems inaccurate to assert that children "beautifully cared for by several different people" would in some ways have an emotional disadvantage to those cared for primarily by one person. In contrast, through the lens of attachment theory and the idea that several secure attachments are better than one, Winnicott's thoughts on the topic are again put in question. Problematically, the modern picture of an extended, complex, and/or multigenerational family system does not seem to fit into

Winnicott's limited perspective of the nuclear family. It is confusing to imagine that the devoted care given by a few or many individuals would not be sufficiently "good enough".

Also, considering the increasing legal and societal acceptance of gay marriage and the shifts in parenting structures that come along with these changes, Winnicott's narrow focus on mothers generates several questions. Are children with lesbian mothers in some way benefitting from the presence of two mothers simply because they are two women while a child of gay male fathers without mothers harmed in some way based on a predominantly male caregiving presence? Similarly single parents are put into question. Can a single father still be "good enough"? Though my personal view would endorse that both mothers and fathers, (biological, adoptive, or foster) are equally capable alternatives for raising mentally and emotionally competent, healthy children, Winnicott's narrow view of the mother's sole importance simply does not address complexities of diverse family structures. Though I agree with the sentiment of Winnicott's writings, that predictable, dedicated, and prepared caregivers are highly beneficial to a child's emotional well-being, I have to argue that these caregivers come in many shapes, sizes, genders, and as parts of a variety of systems beyond those recognized by Winnicott.

In some ways, relational theory seems to be a good supplement to what is not covered by Winnicott's theories. Whereas Winnicott argues for the biological mother's superiority as a primary caregiver, by focusing both on internal and external events and motivators for behavior, relational theory allows for diversity in behavior individually, within societies, and culturally. This allows for any individual to possess the qualities or motivations to be a good enough primary caregiver, without taking gender into consideration. From the views of relational theory, based on both external and individual differences men may have similar insights, behaviors, thoughts, tendencies and capabilities as women, *regardless of their sex or gender* that might make them a

good enough, or even a good caregiver. The concept of the “good enough” mother implies the possibility of a “not good enough” mother (which Winnicott discussed briefly). If it is possible for a “not good enough” mother to exist, then why not the possibility of a primary caregiver who is a “good enough father”? Based on these insights, along with the ways in which traditional ideas on the gender binary continue to be challenged and proven flawed, I would argue that women are not necessarily unique as preferred candidates for primary caregivers.

In the parallel we have drawn to therapy, these questions are equally significant. How do male and female therapists compare? Do the maternal qualities of females make them inherently superior therapists within the therapeutic maternal metaphor? Given the underlying thread of human connection running through Winnicottian, attachment, and relational theories, it seems that connection with a therapist regardless of gender would be beneficial to the patient. This is not to argue that gender does not matter at all within the dyad; consider the individual subjectivity addressed in relational theory- undoubtedly a person’s gender identity and experience of their gender are meaningful and manifest themselves within the person’s larger identity and functioning. Based on this, perhaps an individual patient would benefit from working with someone of a specific gender in therapy (see Ceccoli, 1999). However assuming that a gender has inherent qualities assumes homogeneity within gender; an assumption that is difficult to make in lights of the continually evolving ways in which gender fluidity is being explored, defined, and perceived. I argue that gender itself does not define whether or not a person is a good enough parent, nor a good enough therapist.

Critiquing the maternal metaphor within therapy requires considering the many dynamics at play in therapeutic and mothering relationships. One question that comes to mind is, how does the factor of age play into composing a successful therapeutic dyad? Often mothers, and in many

instances therapists, are associated with a certain wisdom based on age and experience; biologically mothers and fathers are always older than their children. Thinking about challenging the norms of the idea of therapist as mother I wonder, can therapists younger than their clients help the clients in the same way an older therapist might? Just as a peer or younger sibling in may be able to provide connection, holding, or support to a person, it seems logical that a therapist could do so, regardless of age. There are no clear answers here, though I would argue from anecdotal experience that indeed, a therapist younger than the patient might in fact be helpful to or “good enough” for patient who is his or her senior. This area, along with the other interpersonal variables in the therapeutic relationship reflects an important aspect of therapeutic relationship to be studied in future research.

### **Limitations of this Study and Implications for Future Research**

As noted in the introduction, the arguments presented in this study are a personal understanding of this writer’s take on the theories discussed. The writer’s subjective experiences and understandings inherently contribute to the analysis presented here. This analysis is also limited in that the writings on each of the theories discussed are vast, and to reflect on each detail of the theories is out of the scope of this research. Much has been, and will continue to be written in the literature on these topics. It is the hope of this writer that this analysis only contributes to the larger body of knowledge.

As time progresses culture and practices within both mothering and therapy will continue to evolve. It will be crucial that when creating new therapeutic practices relevant to the aforementioned theories, clinicians bear in mind their cultural and temporal relevance. As mentioned previously, the area of same-sex couples parenting is a prominent subject that continues to receive more attention; this area likely has much to teach us about the parenting

relationship, and therefore, the therapeutic relationship. Additionally gender, age (and any other varying individual attributes) and their effects in parenting and therapy are also important topics to continue exploring. Finally, in light of the relative lack of the presence of the unconscious in the theories discussed, the relationship between the role of the unconscious and the importance of human relationship is another area that would be beneficial to study.

## **Conclusion**

What we have seen in this analysis is the apparent importance of human connection in fostering emotional health. Winnicott, Bowlby, Benjamin and the various other relational theorists discussed, have each contributed to this finding in their own ways. Their contributions have been found to be complementary to one another; based on this analysis, it is beneficial for parents and therapists alike to consider the variety of developmental and psychological facets that compose a healthy human connection. Though quite broad, this conclusion helps us to recognize that parents and clinicians using a variety of techniques, of all backgrounds, of diverse cultures, can be united in their focus on relationship as a means for developing emotional regulation. Though this underlying basic concept is unlikely to change (as it can be seen so strongly as a connecting and fundamental theme) the ways in which parents and children, and therapists and their patients engage and connect will undoubtedly shift. Though change often presents challenges, mothers and clinicians can take comfort in the idea that fostering healthy connection is always, “good enough”.

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