

Chapter 2

The Erosion of the Sociopolitical Holding Environment and the Collapse of the Potential Space for Creative Repair

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The term “holding environment,” first coined by the British psychoanalyst Donald Woods Winnicott, has become an established part of the lexicon of mental health professionals representing a wide range of disciplines. The term has a particularly familiar ring for social workers, who grasp intuitively both its manifest meaning and its latent subtleties. We might say this language is, “in our bones,” instilled as practice wisdom gleaned from more than a century of work with our most vulnerable and challenged fellow citizens. Jane Addams was establishing holding environments when she began the settlement house movement, and, similarly, the early Charity Organization Societies served crucial “holding” functions for individuals and communities. Across the spectrum of services, from the provision of concrete services to the conduct of psychotherapy, “holding” has always been the relational backdrop of what social workers do in their various roles with individuals, families, groups, and communities (Applegate, 1997).

As elaborated by Winnicott in conjunction with his second wife, social worker Claire Britton Winnicott, the holding environment concept referred both to the biopsychosocial developmental context in which infants are cared for and to the silent, sustaining therapeutic functions essential to effective helping efforts. Winnicott frequently referred to the holding function of social work. He suggested that “casework might be described as the professionalized aspect of the normal function of parents and local units, a ‘holding’ of persons and of situations, while growth tendencies are given a chance” (Winnicott, 1961, p. 107). Similarly, he (Winnicott, 1963) invited social workers to:

...think of casework as providing a human basket. Clients put all their eggs into one basket which is you (and your agency). They take a risk, and first they must test you to see if you may be able to prove sensitive and reliable or whether you have it in you to repeat the traumatic experiences of their past. (p. 227)

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Expanding the scope of the holding environment concept beyond caregiver–infant and clinician–client, Winnicott (1956) proposed an ecosystem model as well: “One can discern a series—the mother’s body, the mother’s arms, the parental relationship, the home, the family including cousins and near relations, the school, the locality with its police stations, the county with its laws” (p. 310). If he were alive today, he would likely broaden his conception further to include the national and global environments and the social policies that organize them. And, given the state of today’s national and global environments, how might he characterize the integrity of the macro holding environment that we all inhabit now?

We submit that the following sociopolitical factors have deeply eroded the macro holding environment in ways that leave us and our patients subject to destabilizing chronic anxiety: the current crisis in health care (especially the commodification of care exemplified by managed care), the specter of terrorism, the chronic societal trauma of living in a nation engaged in distant brutal wars, the careless plundering of natural resources, the exploitative lending practices that have led countless families to bankruptcy, and the onslaught of media coverage designed to instill fear in our citizenry. We further suggest that these large-scale phenomena insidiously affect all the subsystems of the holding environment, including the settings in which we conduct clinical practice. Not only do we listen to and absorb clients’ narratives of the stresses engendered by an eroded holding environment, we feel the effects of these stresses in our own daily lives, professional and personal.

Beyond its manifest effects, this backdrop of traumatic stress in our practice venues casts shadows of unease onto the unconscious transference/countertransference dialectic that shapes the core of psychoanalytically informed practice. The danger here is that, as we mobilize our own defenses to cope with a traumatogenic world, our reflective capacity to monitor our own inner lives is compromised in ways that impede optimal practice. Moreover, the vast scope of today’s societal stress leaves us feeling stymied in knowing how best to initiate the reparative political and social activism that is so integral to social work’s mission and legacy.

Winnicott (1970) asserted that, under conditions of a rupture in the continuity and felt safety of the holding environment, the developing baby experiences episodes of what he termed primitive agonies or unbearable anxieties—overwhelming feelings of being dropped, falling forever, or experiencing psychosomatic fragmentation. While most of our patients have moved developmentally beyond a vulnerability to such frightening regressions, echoes of these anxieties are likely aroused when they feel “dropped” by societal holding environments. The point here is that living in an environment that no longer “holds” them subjects our patients—and us—to a very basic form of survival anxiety that even the best ego defenses fail to temper.

The Holding Environment and Potential Space

According to the Winnicottian version of early development, as good-enough caregivers provide thousands of holding functions, babies develop an illusion that their needs at a given moment are magically met. Because attuned caregivers “read” the baby’s needs as they arise, they foster in the baby an illusion of omnipotence—“when I need you,

I can make you appear!” Later, with increasing cognitive and emotional development, the baby begins to show signs of becoming more affect-tolerant and self-regulating, signaling caregivers that they do not need to be so perfectly attuned. Busy with something else, they may not rush so quickly in response to the baby’s cry. In the increasingly frequent temporal “spaces” between the baby’s need and the caregivers’ responses, he or she begins to experience a sense of separation between self and others. The illusion of omnipotence gives way to experiences of disillusionment, setting the stage for self-object differentiation and further development.

To cope with their disillusionment, most babies find a caregiver substitute—a blanket, soft toy, or other transitional object that feels, smells, and comforts in ways that evoke the image of the primary caregiver (Winnicott, 1953). Witnessing this developmental milestone, we conclude that the baby has begun to internalize the holding functions of caregivers to be able to self-soothe. Interestingly, this phenomenon typically occurs at around 6 months, the age at which attachment theorists believe a working model of attachment is taking shape. Winnicott (1953) believed that the appropriation of a transitional object is the baby’s first truly creative act. He or she has reached into the inanimate environment to find an object that is imbued with caregiving functions. Holding that object, he or she can conjure an image of the primary caregiver. The object acts as a symbolic bridge over the newly experienced space between self and others, person and environment.

Though the transitional object phenomenon is especially prevalent in the western caregiving contexts, babies universally evince some form of transitional process that enables them to tolerate the anxiety associated with separation-individuation (Applegate, 1989). Other transitional phenomena include lullabies, bedtime stories, prayers, and cultural rituals that become aspects of the baby’s internalized holding environment. Again, they serve to bridge the space between me and not me, an intermediate area of experiencing that Winnicott termed “potential space”—the quietly alive, creative, interactional field wherein fantasy, dreaming, imagination, and play flourish. It is the enlivened area between objective reality and our subjectively constructed conceptions of reality. Winnicott (1953) believed that it is in this metaphorical “space” that we gain the capacity for play and an appreciation for art, music, and religious experiences.

Further, Winnicott (1971) proposed that this potential space is the location of cultural experience. In his formulation, cultural experience becomes an extension of “creative living first manifested in play” (p. 100). Elaborating this idea, Winnicott (1971) continues:

I have used the term cultural experience as an extension of the idea of transitional phenomena and of play without being certain that I can define the word “culture”. The accent indeed is on experience. In using the word culture I am thinking of the inherited tradition. I am thinking of something that is in the common pool of humanity, into which individuals and groups of people may contribute, and from which we all draw *if we have somewhere to put what we find*. (p. 99, italics in original)

The italicized proviso in Winnicott’s last sentence is significant as we consider the current state of sociopolitical affairs. This cautionary note implies that there must be a lively collaborative potential space in which humanity can creatively provide conditions for a supportive holding environment and from which we can draw a sense of safety and enlivening sustenance.

The Collapse of Potential Space

We know that, as a result of trauma and/or chronic stress, the individual's capacity to sustain a reliable mental representation of a secure holding environment is compromised. In turn, both the transitional process and the potential space it generates lose flexibility. Winnicott's formulations about collective potential space suggest that this outcome can apply to the culture as a whole, leading ultimately to the collapse of potential space. We suggest that the collective anxiety associated with the separation panic of being "dropped" by society's "holding" institutions fosters regression to more and more primitive defenses, notably splitting and projection.

We witness evidence of collective splitting and projection on a daily basis. In the absence of potential space within which to encounter the complexity and novelty of human difference with respectful curiosity, our current leaders appear to resort defensively to a split "we-they" representation of the other. Projection serves the purpose of allowing the projectors to avoid awareness of owning thoughts, feelings, or desires that are experienced as ego-dystonic and anxiety arousing. This avoidance is accomplished by placing these internal phenomena outside the self and into groups of others who are targeted consciously as "different," but who are perceived, at an unconscious level, as similar. This process helps the projecting group establish a sense of distance between itself and its disowned parts. Anxiety is kept at bay by defining itself by contrast to the "others" who appear to carry the rejected elements (Lichtenberg, van Beusekom, & Gibbons, 1997).

Psychodynamic thinkers are accustomed to understanding phenomena such as racism, sexism, and homophobia in these terms. At the national/global level, we theorize that the preservation of "our" democratic ideals depends on the violent defeat of a vast "evil empire" of threatening others who appear to embody "our" disowned impulses. The "we-they" configuration generated by such xenophobia makes it possible to dehumanize others and fosters regression to a paranoid-schizoid position (Klein, 1946) that legitimizes oppression and, in the case of war and genocide, torture and elimination of them. Further, the resulting conflict between the two factions joins them in a kind of aversive fusion, closing the potential space for diplomacy and negotiation as adaptive means of problem solving. What is left is fertile ground in which splitting and projection can flourish.

Whither Solutions?

Overwhelmed by the scope of chronic societal stress and trauma, the tendency is toward a resigned passivity. Such a posture leaves the potential space for creative dialogue collapsed. As psychoanalytically informed social workers accustomed to thinking in more activist terms, we are left with a sense of impotence and guilt. One antidote to these feelings is a forceful return to the kind of social action that energized our social work ancestors and served us well during the 1960s and 1970s. There are lessons to be learned by revisiting the revolutionary potential of applied

psychoanalysis. Herein lies the potential for reopening the collective potential space for creative problem solving.

Examples include work by Volkan (1988, 1997) who employs psychoanalytic theory in addressing interethnic and international conflict and violence. He underscores the dynamics of projection as a crucial element of the apparent need for many large sociopolitical groups to have enemies and allies. In applying his formulations to diplomacy, he emphasizes the need for analytically informed consultants to gather conflicted groups in neutral venues to help them mourn collectively past traumas that have spawned generations of violence. Similarly, the political psychologist Ross (1995, 2000, 2001) applies object relations theory to diplomatic interventions aimed at peacemaking in large-scale ethnic conflicts. In an article entitled “Good-Enough Isn’t So Bad: Thinking About Success and Failure in Ethnic Conflict Management” (Ross, 2000), he specifically uses Winnicottian concepts to explore the dynamics of diplomatic negotiation. Both of these scholars can be said to be reopening the collapsed “potential space” for healing and resolution.

These are but two of many theorists who are turning to applied psychoanalysis in their efforts to understand and intervene in social struggle. We can learn much from this body of scholarship, and such study has the potential to inform and reinvigorate our efforts to restore eroded and supportive holding environments for our patients and ourselves. As social workers, we know that this restoration must begin both inside and, through vigorous social action, outside our clinical practices. Inside the office, we can promote and model strategies of self-care and social engagement. Outside, we can write editorials, lobby our legislators, resist practices and policies that dehumanize us and our patients, and raise consciousness among our colleagues by staging conferences like the one exemplified by the symposium that generated this book.

The election of US president Barack Obama in 2008 offers an opportunity to begin to rebuild the sociopolitical holding environment so deeply eroded during the previous 8 years. By reaching out to engage other nations whose differences have led to their becoming objects of dehumanizing projection, this new administration can open the potential space for diplomatic dialogue that recognizes and respects the shared humanity of the global community. At the national level, the hope that energized the Obama campaign appears to be finding expression in social policies designed to provide for more equitable distribution of goods and services across the full spectrum of our citizenry. Nevertheless, as demonstrated by the upsurge of resistance against the 2009 efforts to realize the goal of universal health care, the need for our activism is as urgent as ever. Analytically informed social workers have unique perspectives and decades of experience to bring to the inevitable struggle that will accompany the process of social change.

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