Abstract. I offer a retrospective view of the evolving baby metaphor in relational thinking. Early relational critiques of developmental tilt models and the concept of holding in clinical work, amplified by feminist writers, sharply skewed relationalists toward a vision of the patient-as-adult and a view of the analytic dialogue as inherently intersubjective. Bringing my own Winnicottian/relational perspective to this critique, I expanded the notion of holding and proposed a way to bridge Winnicottian holding with a relational perspective by exploring the analyst’s participation in establishing and maintaining a holding experience. Here, I review and update this controversy, offering new ideas about holding’s clinical function in buffering shame states.

Keywords: developmental tilt, Winnicott, relational theory, holding, intersubjectivity, patient as baby

I grew up, psychoanalytically speaking, in the 1980s. In graduate school I was introduced to object relations theories and rapidly fell in love, especially with Winnicott. At once quirky and maternal, Winnicott’s writings evoked a vision of affective responsivity, of a new, improved mother/father. That vision generated a powerful response. If the analyst symbolically can become the mother, the possibility of reworking early trauma is enormously increased: what cannot be remembered can be reexperienced and then repaired; the patient can be a baby again, but with a better, more responsive (symbolic) mother.

There’s no doubt that fantasies—both unconscious and explicit—of parental repair are alive and well in the consulting room. The morning of this writing, a businesswoman patient who usually experiences herself as enormously grown up and feels that I am a helpful consultant-peer sat down and said, “I have to tell you that I feel like curling up into a ball and...
weeping like a little girl. I've been waiting so long to get here. I can't believe it's only been a week and I can't believe how dependent I feel." She didn't stay there, but for a moment she touched a baby wish; as it came affectively alive, I resonated—both with her wish and with the possibility of meeting it. This phenomenon is so common as to be commonplace, though its place in our theorizing varies widely.

Patients as vulnerable, dependent babies. Not Freud's Oedipally organized, conflicted neurotics or Klein's raging, biting ones. In some ways, Ferenczi's; his (1932/1988) emphasis on the therapeutic function of regression is, in many respects, close to Winnicott's. And, of course, the British Middle Group's, who reconceived psychoanalytic process as symbolic maternal repair for what we would now call relational trauma. Inviting the needy baby state—and nurturing maternal response—into the consulting room, they envisioned an analyst who could meet need, remain steady and empathic, bearing strain without retaliating.

Developmental metaphors changed the clinical landscape by moving analytic work away from a focus on sexual and aggressive conflict (the repeated relationship) and toward the needed one (S. Stern, 1994). That shift did not preclude interpretation, but it directed those interpretations toward vulnerability. Maternal metaphors gave a name and shape to something that had remained largely unspoken—the clinical value of empathic responsivity. Now it was theorized: dependence was not defensive because early need was real and needed real repair.

Of course, this clinical perspective was not universally embraced. It seemed to conflate wish and need, as if repair could replace the analysis of conflict. Where in this model were the dynamics of aggression and envy—of attachment to bad objects?

Another kind of critique was articulated by interpersonal and social constructivist writers. They rejected both sides of the maternal metaphor (patient-baby and analyst-mother) along with the assumptions on which it lay (e.g., Mitchell, 1984, 1988, 1993; Hoffman, 1991; D. Stern, 1992; Aron, 1992). Those assumptions—of analytic certainty, knowledge, power, and the possibility of delineating historical "truth"—were sharply challenged. The relational analyst is neither omniscient nor omnipotent; further, the patient knows far more than a baby could. What was no longer is; the patient brings her adult self (with all its attendant conflicts and complex ways of experiencing things) to the consulting room. When enacted, developmental illusions create an "as if" therapeutic situation
that locks the patient into a position of helpless dependence while encouraging the analyst's grandiosity.

Adding to this critique were voices rooted in feminist thinking. Beginning in the 1960s, feminists challenged both the idealization of motherhood and its associated demand for maternal self-abnegation, noting that these traditional views obliterated the father and located all the child's pathology in the maternal lap. They precluded the idea, no matter the experience, of mother-as-person.

For me, a young mother struggling to balance career and parenthood, the feminist critique hit home. I both wanted and felt I had to do it all, and do it awfully well. So it was quite a relief to discover a children's recording by American singer Marlo Thomas entitled "Free to be you and me." It included a song with this chorus: "Mommies are people, people with children." The sense, finally, of recognition. (I still know all the words.) Today, I think it's shocking how shocking those words were. Yet now, more than three decades later, I occasionally fight the impulse to sing it to my all "grown up" and married children. For although mommies eventually become subjects to their children, it's the rare child who steadily sustains that awareness. And in many ways, the same is true of patients vis-à-vis their analysts.

Picking up and elaborating this argument, feminist psychoanalysts took up the gauntlet and carried it into the consulting room, critiquing dichotomized depictions of gender (e.g., Dinnerstein, 1976; Chodorow, 1978; Fast, 1984; Benjamin, 1986, 1988; Harris, 1991, 1997; Dimen, 1991; Goldner, 1991; Bassin, 1997, 1999; Layton, 1998; Bassin, Honey, & Kaplan, 1994; Kraemer, 1996). Visions of what Grand (2000) calls maternal bounty, of analyst-as-earth-mother, negate the irreducible nature of analytic subjectivity (Renik, 1993). They exclude the analyst's nonresonant emotional responses to patient need; they render her all-giving and ever-present. And they ignore the pre-Oedipal father.

So, is there a baby in the consulting room or not? And if there is, is she discovered, or was she created—by an analyst whose theoretical bias obfuscates the actual? Early relational thinkers were clear: there's neither a baby nor a mother in the consulting room. Just two grownups.

It was here that my own work came on the scene. Influenced by the feminist movement, Benjamin's work (1988, 1995), and Mitchell's developmental tilt critique, I proposed a clinical/theoretical alteration to the holding metaphor that could be contained within relational theory, albeit in an expanded and complicated form (Slochower, 1991, 1992, 1993,

**Holding in a Relational Frame**

In *Holding and Psychoanalysis*, I made a plea for an expanded vision of empathic responsivity, reconceived to account for the relational and feminist critiques and expanded to encompass a developmental trajectory that extended beyond the nursery, i.e., beyond the theme of dependence. Here’s a brief summary: There are limits to the clinical value of intersubjective work. Some patients cannot tolerate or integrate evidence of the analyst’s otherness without prolonged derailment that shuts down (rather than opens up) the therapeutic process. Analytic holding is a useful clinical response to this kind of vulnerability.

I use the holding metaphor to capture my imperfect effort to remain within an emotionally resonant therapeutic space while I refrain from confronting my patient with “discrepant” ideas and affective communications that I suspect would have a derailing impact. Holding describes my attempt to remain within whatever affective frame a patient anticipates (and needs) me to be in. This kind of protected space can have a powerful therapeutic impact with people whose emotional experience was chronically obliterated.

Central to this way of conceptualizing holding is my belief that it isn’t always organized around dependence: Holding doesn’t necessarily mean being “empathic,” “gentle,” or “softly attuned.” Although I sometimes hold dependence, I also hold states like self-involvement, rage, and contempt. In all these situations, holding means accepting—rather than challenging, interpreting, or countering—my patient’s emotional state and view of me. Thus, although a dependent patient may long for and receive my gentle empathy, a narcissistic patient may want me to stay “out” because she needs the treatment space to be all hers. Holding narcissism means trying to tolerate sitting on my hands while refraining from explicitly introducing myself (my ideas or my feelings). Holding a hostile, denigrating patient means trying to accept her dismissiveness (or her belief that I’m incompetent) without interpreting or challenging it. In conjunction with this kind of acceptance, I indirectly (implicitly) communicate that I’m resilient enough to survive her attack without retaliating (Winnicott, 1971), although I am, perhaps, a bit irritated (as she expects me to be). Holding
rage means struggling to accept and not counter my patient’s hate and her belief that I deserve her hate—that I am the perpetrator—while containing my wish to confront her with her destructiveness, interpret the reenactment, defend myself, or counterattack (Davies & Frawley, 1994; Grand, 2000, 2010).

Holding, then, takes many clinical forms outside work around regression to dependence. Here’s the red thread: Whenever I hold, I try to articulate, contain, and moderate my patient’s affect state while minimizing the derailing impact of my otherness. I hold by accepting, without implicit or direct challenge, her perceptions or fantasies about me. I’m not a “like subject” because I don’t necessarily feel what she feels and in this sense I’m “other.” But there’s a paradoxical resonance inherent in my “otherness” because it’s the otherness that my patient expects to find. I am the person (the other) she imagines me to be—whether this means that I’m empathically attuned, dense, remote, incompetent, stupid, or otherwise (predictably) different. My difference is paradoxically resonant with her expectation, and in this sense, I’m recognizable rather than jarringly different.

Because holding permits a blurring of the permeable boundary between me and my patient, it allows an illusion of attunement to dominate. That illusion buffers unexpected and disturbing (rather than anticipated) evidence of my otherness. By not countering or even complicating my patient’s experience of me, I create more emotional room within which she can contact, elaborate, and fully express a range of feelings about herself and me in a context that’s containing rather than challenging. Holding thus embodies (via interpretive action [Ogden, 1994]), our joint survival: as I recognize and accept my patient’s difficult feelings, I survive—I don’t collapse and I don’t retaliate. All this symbolically provides a double communication: I am affected, but not engulfed, obliterated, destroyed, or enraged by you. Over time, my patient comes to feel seen not from the outside in, but from the inside out (Bromberg, 1991).¹

¹ Kohut’s notion of the selfobject function is, in some ways, similar to my description of analytic holding. Although I think holding involves this kind of empathic stance, there are also some central distinctions: I view the holding function as a more limited clinical response to a particular vulnerability that will give way to collaborative work as the treatment progresses; I link holding with a wider range of affect states; I also explicitly include the analyst’s struggle with her dissonant subjectivity in the holding concept. I explore overlaps and divergences in more detail in Holding and Psychoanalysis (Slochower, 1996a, 2014).
So What’s Relational about Holding?

My work on holding extended the Winnicottian metaphor to a range of difficult affect states other than dependence. A relational holding model explicitly reflects the relational turn in two ways: 1) it includes the analyst’s omnipresent subjectivity within the holding moment rather than assuming that her state will or should be congruent with the patient’s expectation; and 2) it views the holding moment as coconstructed, i.e., as involving the patient’s implicit participation (along with the analyst’s) in excluding what’s discrepant.

From a relational perspective, we need to do something with ourselves if we are to hold because we can’t delete our separate experience from the clinical moment. To hold my patient, I also need to hold myself—to hold (rather than express) those feelings and ideas that would disrupt the illusion of attunement on which my patient relies. I hold not by feeling what my patient expects me to feel, but by struggling to bracket, rather than express or delete, my disjunctive subjectivity.

I invoked the idea of bracketing subjectivity to capture the doubleness of the analyst’s experience during holding, the there-but-not-there quality of her subjectivity. I may well feel stressed, tired, impatient, or furious in ways that my patient doesn’t anticipate. But when I sense that the introduction of my separate perspective would be deeply disturbing, anxiety arousing, or otherwise derailing to my patient, I do my best to bracket what I’m feeling and thinking. Bracketing means noting, struggling with, and trying to set aside my reaction rather than disavowing it.

It’s difficult to describe all this without making it sound deliberate, even choreographed. But in my view, shifts in and out of a holding metaphor are anything but: They are multiply determined by both conscious, intentional and unconscious elements. In part, I move toward holding based on my clinical/theoretical point of entree. In part, this shift is procedural, a spontaneous reaction to aspects of my own experience that I don’t even know I’m having. In part, it’s enacted, responsive to pulls and pushes from my patient that are at once responsive to the pulls and pushes that come from me. And to complicate things even further, some of the time I (we all) fail when we try to hold—because I think I know what’s needed but don’t actually know; because I’m in the throes of an enactment, self-object failure, or other kind of misattunement. That is, there are clear limits to what I can hold and what I can bracket, because I can’t bracket
what I don’t know I’m feeling (and I can’t hold what I don’t know needs holding). For another, many of my patients are pretty perceptive (sometimes more than I’d like), and may well pick up aspects of my reactions despite my attempts at bracketing and holding.

So (and here’s another relational alteration to the holding metaphor): bracketing takes two. When my patient needs not to know something about me, she does as much, even more, bracketing than I: She shields herself from those aspects of my otherness (my variability, reactivity, and so on) that would disrupt the sense of resonance on which she relies.

The concept of mutual bracketing moves holding out of the analyst’s corner and into dyadic space, reversing the asymmetry associated with the holding metaphor. A most dramatic instance of this kind of bracketing harkens back to my days as a young analyst, very pregnant with my third child. At eight months I was enormous. Feeling that I could no longer wait for my patient, Jonathan, neither very ill nor especially dissociative, to address the obvious, I said, “there’s something we need to talk about.” Fully expecting him to acknowledge that he hadn’t wanted to bring my pregnancy up, but of course had noticed, I didn’t anticipate that he would do a double take and virtually fall back into the chair, stunned.

Jonathan’s need to see us as a couple within protected therapeutic space utterly obfuscated my pregnancy, a most concrete indication of my otherness. He excluded it and what it represented (the prospect of a symbolic sibling, not to mention my shadow husband—the unseen sexual partner who fathered this child). In so doing, Jonathan sustained an essential experience of togetherness with me, the first such experience he could recall. Ours was not a holding space reminiscent of the nursery, though. Jonathan felt me to be more of a peer/older sister who was identified with his needs and able to be together with him in them. An element of twinship merged with maternal longings to render me “a woman, but just like him.” Hence, not pregnant. And as much as I consciously “wanted” to be seen in my expectant state, perhaps on another level I unconsciously supported his bracketing via my wish to protect our relationship (and my baby), leaving the latter outside therapeutic space.

Eventually Jonathan and I talked about this, about what he had needed to miss and why. Our conversations filled in and thickened the therap-

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2 See also the case of Sarah (Slochower, 1996a, pp. 49–50). Involved in a powerful need for emotional resonance, Sarah bracketed a dramatic interruption in our phone session (I was badly scratched by a cat) and continued as if nothing had happened.
tic dialogue, but I'm pretty sure that they couldn't have taken place had I insistently introduced my pregnancy early on. And it's worth noting that I never told Jonathan that I had been bothered by his oblivion to my pregnancy. I chose not to, because I sensed that this kind of disclosure would have been intensely shaming to this sensitive, shy man. I will pick up this theme again in a bit.

Holding in the Clinical Moment

When I work within a holding metaphor, I pay especially close attention to my patient's emotional responses to evidence of my otherness, that is, my "separate" thoughts, reactions, ideas. I'm not referring to whether or not my patient accepts what I say: a loud "no damn way, you're wrong" can be the opener for a rich and useful interchange. But when my patient consistently shuts down at these times, when she is unable to accept and work with, or reject my perspective while sustaining her own, I sit up, therapeutically speaking. I ask myself whether I might be off base, emotionally or dynamically, whether we're involved in a potentially useful—or very problematic—reenactment. Is my patient reacting to my being too much like "old objects" or too different from them?

I move toward holding when this element of derailment in response to disruption becomes chronic. By resonating with and accepting my patient's feeling or perception, containing the "but" that would be implicit in my attempt to interpret or deepen my patient's understanding ("but you could experience or see it differently"), more space is established within which she can define, moderate, and elaborate the feeling's shape and edges. Within a protected holding space, my patient may become able to identify, perhaps amplify, aspects of a nascent, unarticulated, or only partially articulated experience (Slochower, 2004).

The holding metaphor embodies connection: As I hold, I symbolically (occasionally literally) hold out my hand in response to a moment of intense feeling, countering a painful sense of isolation or terror. As I hold my patient in mind, I carry an emotional memory of her affect state between our sessions, which serves to contain her vulnerability to flooding and/or a sense of being dropped.

Of course, holding isn't enough. Even those of us who privilege analytic holding do far more than this and the rest of what we do counts a lot. Whether we identify the holding dimension as figure or as ground depends on our theory. But I'm convinced that the need for this kind of
resonant recognition remains an alive layer of human experience across our lifetimes. This is where the shadow holding element comes in: It guides us on a procedural level with regard to when and how we enter the clinical dialogue, how directly and how deeply.

At moments, holding helps my patient down-regulate (in Beebe and Lachmann's terms [e.g., Beebe, Lachmann, Markese, & Bahrick, 2012]): she moves out of a flooded emotional state toward greater emotional equilibrium. Down-regulation may involve Bion's (1962) container function wherein I absorb, metabolize, and reintroduce toxic affect states. Flooding hatred becomes irritation; overwhelming longing becomes wished-for connection. Alternatively, down-regulation might occur via the interactive dyadic dance that Beebe and Lachmann (1994) discuss. I respond to my patient's rage or longing as she reacts to my emotional presence and capacity to contain. Together we quiet the intense emotional tone that was evoked; there's no clear starting point (or person), but gradually the intensity of my patient's state diminishes and she settles a bit.

Whatever its particular shape, the holding metaphor pulls us to partially set aside the parental/analytic protest (“Hey, wait a minute. What about me? Mommies/analysts are people too.”). So holding requires a lot of self-holding on the analyst's part. And despite what some critics think, holding patients usually isn't fun or easy: It can feel oppressive, limiting, can leave us thinking that we're not doing enough work or that we're constantly holding our breath, staying too still, tracking our patient too closely. Holding hate and contempt is even more difficult. As Davies (2004), Epstein (1987), and others remind us, when we're bad objects to our patients, we're also bad objects to ourselves. It's not only our patients who need holding.

Holding and Mutuality: False Dichotomies

There has been a tendency to position holding and mutuality as a polarity characterized by nondisclosure on one end and full disclosure on the other. But it's a false dichotomy, and one that most of us have moved beyond. Despite our best attempts at containment, aspects of our personhood—its dimensionality and its limits—leak into therapeutic space. It's inevitable; we cannot not show ourselves. Besides which, we show plenty of ourselves by virtue of how and when we hold.
But the other end of this polarity is equally elusive: Even when we aim for full disclosure, for ongoing mutual exploration, we never quite get there. Nor, I believe, should we. Full disclosure is impossible (because we analysts have our own unconscious experience). It is also undesirable. No matter how much we value intersubjectivity, there will always be things—information, feelings, experiences—that we choose not to tell because of our own wish for privacy and/or because we suspect that it would be too disruptive, too disturbing, or too hurtful to do otherwise. We choose (partially unconsciously) what we try to bracket—i.e., contain and study—and express based on a mixture of our patient's and our own needs, wishes, and anxieties, along with our clinical ideas about what's therapeutic and what's not. And I'm convinced this is true no matter where we sit on the restraint–expressivity continuum.

Clinical theories—like political positions—are almost always formulated in opposition to clashing ones, an ongoing series of correctives that often become pendulum swings. Early relational writing represented a corrective to the excesses of hierarchical, one-person, drive-based theories (Greenberg & Mitchell, 1983). My work on holding represented an attempt to rebalance that corrective in a third direction by detailing the limits of mutuality. It provoked its own reaction, and in the 1990s Bass (1996) and I had a lively argument around the question of whether it's possible to hold, rather than to hold back or hold on; that is, whether holding merely obfuscates the elephants in the room.

But there are always elephants in the room. First, we're always holding something back no matter how little we intentionally hold; second, we're always expressing aspects of our subjectivity, no matter how hard we try to hold. So rather than positioning these two positions as polarities, let's make room for both and detail how each clinical position is—and is not—responsive to the needs of different patients.

Over time, the centrality of the developmental tilt critique has waned. Mitchell's later writing anticipated that shift: Influenced by Loewald, the attachment theorists, Benjamin and, perhaps, my own position, Mitchell increasingly focused on the role of early relational dynamics as they inform analytic experience in both cognitive and affective realms. Although he never explicitly privileged the patient's baby needs or spoke about meeting them symbolically, he no longer insisted on patient-as-adult. By the time he wrote _Relationality_ (published in 2003), Mitchell had articulated four interactive modes through which patterns of connection be-
come organized. This was a layered vision of an adult influenced by a range of relational modalities, at least some of which originate in infancy. It underscored the multiplicity of self-experience and suggested that there are ways in which, at once or in rapid alternation, the adult moves between grownup, child, and baby states.

Today we’ve increasingly embraced developmental models that include the idea of patient-as-baby. These more sophisticated frameworks have moved away from schematic models that lean on linear visions of development; notions of a fixed and sequential growth process collide with theories of nonlinear movement and multiple self-states (Bromberg, 1991; Mitchell, 1993; Davies & Frawley, 1994; Goldner, 1991; Corbett, 2008; Harris, 2009).

Yet theories of multiplicity don’t negate the possibility of baby experience within analytic process; they make room for her. Or him. Because if self-states are moving, rather than unitary, we don’t have to choose between baby and grownup. Even when our patient feels like an adult, she has the capacity—perhaps disavowed, perhaps not—to access and even temporarily move into a baby state. And vice versa.

Over the last decade, other relational strands, too many to catalogue here, have entered the developmental conversation (Seligman, 2003). Perhaps most pivotal has been the contribution of attachment research and dynamic systems theories (e.g., Ainsworth 1969; Hess & Main, 2000; Stolorow, 1997; Beebe & Lachmann, 1994, 2002; Beebe, Lachmann, Markese, & Bahrick 2012). Discussions of the processes that underlie different comfort-seeking patterns (e.g., Hesse & Main, 2000), along with an exploration of mutual regulatory interactive processes, fill in our understanding of what’s behind the global holding metaphor. They identify and unpack its nonverbal dimension.

Early attachment patterns make themselves felt across time, even as they transform. In this sense, infant researchers have invited baby states back into the consulting room and addressed the baby’s legacy, if not the baby herself, while turning an eye to the mother’s (and analyst’s) complex role in co-shaping these patterns. I’d add that the analyst’s own babyhood is implicated here; at moments, there may be two babies in the consulting room; the analyst’s early regulatory patterns are activated along with—and in reaction to—the patient’s. Certainly, this (empirical) baby, formulated on the basis of infant research findings, is not the object relations theorists’ vulnerable recipient of good—or not good enough—maternal care. She is a different, more active kind of baby, reactive to and a par-
participant in mother’s own pulls and pushes. Still, the legacy of those early patterns can be found in analytic space because the adult patient’s distressed states sometimes carry the shadow of that baby.


The need for moments of attuned responsiveness emerges across our lifetime, however grownup, “separated,” or reflective we are (Ogden’s [1986, 1989] idea of simultaneous but shifting affective modalities make this clear). And I don’t think this need is limited to patients with a history of massive early trauma; almost all my patients (and all of us analysts) have moments when that “no longer baby” is as palpable as is our own parental identification and reparative fantasy. Like my very grownup businesswoman patient who felt like melting into my chair on one cold November afternoon, or my Wall Street patient who phoned me last week in a panic because something his wife said made him feel that the sky was falling. For the first time in his remembered life, he had someone to call; I became, for a moment, a soothing presence, someone who could receive his distress, accept rather than counter it without also becoming disregulated. He felt held and slowly calmed down enough to think about what he was feeling. Together we enacted a version of the parental metaphor. But just for that moment.

It’s the concrete that gets us into trouble: When we insist that the patient is a baby or when we insist that she’s an adult capable of mutuality, we run the risk of demanding a kind of false self compliance. We skip over the interpenetrating nature of baby and grownup self-states and pull for one or the other in a way that may well feel “as if” or pseudo. Either can be shaming of the patient. The patient seen as baby may feel shame over her envy or hate; the patient seen as an “adult” may feel shame over her vulnerability and merger longings.

**Holding’s Dynamic Function: Buffering Shame States**

Holding alludes to the enacted reparative element, a sort of corrective emotional experience. We don’t call it corrective in Alexander’s (1950) sense when we hold or when we function as a “new object,” but we are
doing something awfully close to that by helping create antidotes to toxic internalized object experiences, and perhaps especially, to shame states (see Cooper, 2007; Davies, 2004; Hoffman, 2008, 2009).

Whenever and however we hold, we bear witness to our patient's experience without challenging it; we privilege her perspective on herself and allow it to unfold, received but not altered. This kind of therapeutic process is especially mutative with patients who are intensely vulnerable to shame states (see Orange, 2008; Morrison, 1989; Bromberg, 2010). Shame experiences, often organized around a sense of exposure to an unfriendly eye, are activated by the feeling of being seen from the outside, looked "at," looked down upon. Holding buffers shame because the experience of affective attunement—however it's configured—creates a shield against this sense of exposure. Holding allows the illusion of analytic resonance to remain unchallenged and uncomplicated so that my patient comes to feel with me rather than seen by me. Over time, holding may allow a scaffolding to coalesce, which protects against humiliation. It eventually will allow us to enter the arena of shame. Together.

Over the years, I've given many examples of work dominated by a holding metaphor organized around affect states like dependence, rage, narcissism, and ruthlessness, and illustrated how the holding trope gradually evolved toward collaboration (intersubjective exchange). Although holding's function in buffering shame was implicit in some of those examples, it was not explicit. Here I illustrate and then further discuss how moments of holding (organized outside the arena of the maternal metaphor) served primarily to buffer shame.

Mark, an academic in his early 50s, came for analysis about a decade ago. He had grown up with a contemptuous, physically abusive father and a passive, mostly absent mother who seemed not to connect much to him. Mark's young adulthood was characterized by drift—from relationship to relationship and career to career. In early middle age, Mark met his current partner, Chris, and something about Chris's stable evenness repaired things enough for Mark to settle into a reasonably solid relationship and career, although his traumatic history periodically made itself known. Coming to me at Chris's request, Mark was defensive, argumentative, and avoidant, but also ruefully aware that his irritability was casting a pall on his relationship. As he put it, "Chris will kill me if I don't do this. But then again, I might just kill him and myself first. Metaphorically speaking only, of course."

Smart and funny, yet staving off a major depression, Mark settled into
a three times weekly treatment. He was self-reflective in an intellectualized sort of way, shifting between angry, bitter moods, and a more curious and lively sense of self. He could think about his past and connect it to his choice of partner, someone with whom it was safe to get angry. Mark also noted that there had been no mother there to be angry with, teasingly adding that it was a good thing I had a bigger impact than my size might suggest. Mark’s easy humor would become a mainstay of our work.

But mostly Mark wasn’t funny; he was painfully sad and bitter. Listening to his reminiscences, I imagined this little boy’s loneliness and fear as he contended with his powerful, irritable father and absent mother. Because Mark spoke so freely, I wasn’t immediately aware that things went well only when I just listened. When I did enter the conversation actively—whether to ask a question, comment, or offer a tentative interpretation, when I expressed my sense of what Mark was feeling or why he might be saying something, things went less well. Mark would pause briefly and then go on speaking as if he hadn’t heard me. Occasionally, he nodded before continuing, but his nod felt mainly like a way to get me to shut up. When I was particularly persistent, Mark changed the subject—usually to something external to us both. When Mark described especially painful memories and I reacted verbally (e.g., saying) “that sounds just awful,” or even making an empathic sound—he paused only briefly before either cracking a joke or altogether leaving the interior arena and launching into a description of something going on outside, in the world. When I asked Mark whether what I had said bothered him, he ignored my question, sometimes cracked another joke, but always moved into a third space. Mostly that third space involved the political scene and his sophisticated analysis of it. Although aware of its defensive function, I found myself engrossed by Mark’s astute (and resonant) perspective and amused by his joke telling.

Yet I also knew that we were using these conversations as a way out of the self-conscious state into which Mark feared he would fall—or already had fallen. Mark needed to keep himself (and us) at a distance, and although anxieties about merger probably underlay this need, it seemed impossible to name. Much was left unspoken. And so, when the moment seemed as right as it ever was, I tried to gently name some of this. Mark grew very still on the couch. Nodding, he flushed intensely but remained silent. Waiting a bit, I said even more gently that I thought I had just embarrassed him a lot, that being seen or understood by me felt painfully
exposing. After a pause, Mark nodded and said, almost in a whisper, “please don’t.” Sensing that he couldn’t say more, I said only “I’ll try.” And I did. Mostly.

Mark tolerated engaging with me only when our bond stayed light and humorous. I struggled to honor that (to hold him) by giving him space and containing my feelings, especially my resonant sadness with Mark’s pain, pain that was almost always thinly veiled with humor. Expressing my empathic sadness intensified Mark’s pain in a way that was unbearable and derailed the protected space in which he dwelled. And so we—or Mark—undertook a kind of self-analysis, to which I was witness more than participant.

It was another full year before Mark cried in my office, and longer still before he allowed himself to express the wish, no matter the need, for my input, let alone my caring. But, in time, all that came about, and gradually Mark’s “self analysis” became a dyadic one. With a decade of work behind us, we’re getting close to getting done, and spoke recently about the idea of terminating.

Still, Mark’s skittishness remains a clear and present thread. Now, though, he announces his intensifying defensiveness with a joke: “OK, enough of your thoughts. I’m taking a sharp left turn,” turning away from himself and into left-wing politics. Smart, funny, interesting, he banter and I banter back. We laugh, occasionally we debate a bit. It’s fun for us both.

Ordinarily, I don’t connect humor with holding; it’s a register that feels more spontaneous, easy; it embodies so much of one’s subjectivity, so much interpenetrating affect. But I’ve come to think about Mark’s humor and my amused response as providing a cocreated holding function, albeit an atypical one. It emerges whenever Mark touches edges of his traumatic history or potential need for me, when his sense of intactness becomes acutely threatened. Mark beats a quick retreat from both into the land of humor, into his version of Jon Stewart’s “The Daily Show,” a television show (by a liberal political commentator) that we both love. Mark’s jokes get me to laugh (a lot) and rebalance things between us because as I do, he experiences aspects of his own agency and aliveness while also symbolically enlivening his deadened, depressed mother. Our shared humor serves as a buffer against the double threats of humiliating exposure (in the face of an unresponsive object) and assault, both precipitants of acute shame states.

But I don’t want to leave you with the impression that holding was all
that happened in Mark’s treatment. It wasn’t; there was also lots of work that had nothing much to do with holding. I did plenty of interpreting and sometimes spoke directly (and a bit confrontationally) to Mark about aspects of my (difficult) experience of him, about his edginess and sarcasm. There were reenactments as well, times when I failed Mark in just the way he needed me not to fail. All of these had their own therapeutic—and countertherapeutic—effects. We struggled and did some negotiating (Pizer, 1998). I could, in fact, write a whole paper on the enactments and negotiations in Mark’s treatment. But because here I’m thinking about babies, I’m tilting things the other way and underscoring the backdrop against which all this more juicy stuff took place. Like Sandler’s (1960) background of safety, our laughter was the linchpin around which the rest was organized. Though perhaps some of you would say that enactments were the linchpin, and holding the thing that killed time between them, as Spezzano (1998) put it.

Mark’s intense vulnerability to shame states made it near impossible to name or explore them, yet they lurked at the edge of nearly everything he spoke about. And when intensely evoked, they were intensely derailing. I suspect that my laughter, via processes of interpretive action (Ogden, 1994), helped Mark access and sustain a nonhumiliated self-state at the very moment of most acute shame. Recently he put words to this: “Sometimes I thought I was a pathetic, slobbery, wimp. Someone everyone would point at and laugh at. So instead, I got you to laugh, and when you did, I refound another part of me. And I no longer felt ashamed.” Only now, with an end in sight, are we explicitly opening up and working with these shame dynamics. It seems likely that this is the last chunk of work we need to do: essential, but elusive outside the holding experience.

When I hold, I become an “insider” witness who remains firmly within my patient’s perspective, affirming rather than challenging it. The “it” that evokes shame will vary widely. For many patients (including Mark), and sometimes for the analyst as well (Stein, 1997), shame is connected with what feels like the exposure of baby needs. For others, though, shame is evoked by states like anger, desire, or greed. And, ironically, sometimes it’s the holding experience itself that evokes shame. I imagine you won’t be surprised to hear that, in the context of our tentative exploration of shame, Mark once said, “I need not to need you to be any particular way with me. If I feel your support, I feel ashamed of the fact that I want it. It has to be okay for you to be however you are being. And it’s not.” At that point in our work, there was no evading shame.
The therapeutic power of witnessing has been the subject of writing on major trauma (Laub, 1992; Grand, 2000, 2010; Boulanger, 2008; Gerson, 2009; Harris, 2009; Harris & Botticelli, 2010; Rosenblum, 2009 Laub & Auerhahn, 1993; Laub & Podell, 1995). This literature supports witnessing's reparative impact in work with Holocaust survivors and other victims of the unspeakable. Yet I think it's also true that all our patients—and all of us—have been traumatized insofar as we all have had the experience of nonrecognition in moments of acute need (D. Stern, 2009).

Holding and Its Underbelly

Visions of analytic holding are romantic, even seductive. They encourage fantasies about our capacity for therapeutic repair and affirm our generative parental identification. They counter a range of anxieties about who we are (and aren't); about what we can and can't do for our patients. In many ways, these visions support and steady us when the going gets rough; but in some ways they may not (Slochower, 2006).

Holding, like many Winnicottian concepts, invites overuse, indeed, misuse. The holding construct can be invoked in ways that are too schematic, over-read, bled of its therapeutic usefulness. Nearly any intervention can be justified as holding, supporting a regression, expanding transitional space—in fact, it’s an idea that can be invoked to describe almost anything we do other than actively confront or piercingly interpret. Holding can be used to justify inaction, to quickly categorize what we’re doing and why. I’ve heard analysts describe having held a patient by literally giving her a transitional object—as if anyone but the patient can imbue the concrete with transitionality. A supervisee once described how he held his patient by remaining absolutely impassive in response to a photo of the patient’s new, beautiful girlfriend. I’d say he was being competitively withholding and called his behavior “holding” to rationalize.

In a similar way, holding a regression to dependence has mostly lost its original meaning as an organized response to a patient—by an analyst capable of receiving and containing intense affect states (early need/rage and so on)—without collapsing or retaliating. Too often, holding is conflated with the notion of regression, a return to earlier, “immature” modes of relating, a blueprint for a kind of straight-line therapeutic process in which we repair the baby. As if there was ever simply a baby/patient.

In any event, it was never merely babies who needed holding. Older children—and we adults—sometimes need it too, sometimes from within
a much younger self-state, sometimes from a very adult self-state but very vulnerable one. Last night, in fact, I had a long conversation with someone experiencing a terribly frightening medical crisis. In her own language, she told me how held she felt by people’s capacity to meet her where she was emotionally, even though she hadn’t asked. There’s nothing infantile about that. It’s just human.

The Takeaway

Baby and child metaphors express the phenomenological reality of these states while temporarily ignoring the other actuality—that of patient-as-adult. I think we can, finally, take both for granted. And although these developmental metaphors have been critiqued for their idealization of both the analytic and therapeutic function, it seems to me that even when we formulate therapeutic process outside the idea of holding—whether we think about patients’ needs for confrontation, authenticity, mutuality, selfobject experiences, or recognition—we idealize something.

Our ideal represents our wish—and often also our need—to heal, to change, to engage, to do something useful. Of course, our personhood limits our capacity to meet that ideal, and confronts us with what I’ve called a psychoanalytic collision (Slochower, 2006, 2014). Collisions emerge, independent of our theoretical allegiance, out of the space between the professional ideal to which we aspire and the actuality of our human fallibility.

As I wrote this article, I confronted my own collision: Despite my immersion in the holding theme, I don’t often work like a Winnicottian. I usually play it pretty straight; that is, I try hard to find a way to articulate what I’m thinking and why, and I “hold back” very little. Indeed, many of my patients have pointed out (often—but not always—affectionately), that I hardly seem like a holding analyst to them; I’m more often described as someone who “calls a spade a spade,” albeit nicely. Further, much of me is embedded within the holding metaphor, reflected in the ways I try to hold.

Over time, I’ve become more expressive of my subjectivity, more relaxed. A bit less cautious. Yet nearly everything I do by way of exploration, interpretation, confrontation, and reenactment takes place within an envelope characterized by a background awareness of the potential need for holding, of my patient’s vulnerability to shame experiences. So, in a way, I hold even when I push. All this, of course, gets experienced and expressed in a range of ways (good and bad) by different patients.
So, to get back to the beginning: There's no simple baby—or adult—in the consulting room because both members of the dyad move from moment to moment, imperceptibly and unconsciously—toward and away from relating to the other as a collaborative subject. In this process, patient and analyst contact, enact, and perhaps meet the needs of these baby and child self-states, for better and for worse.

We don't have to abandon the idea of a psychoanalytic baby because it can, in fact, swim in relational bathwater—bathwater that includes an analyst who holds and who fails to hold, who is mostly (but not always)—capable of being a reflective professional who has access to her own baby self-states and sometimes mixes it up with her patient. The developmental trajectory, such as it is, has so many bumps and reversals that it would be absurd to call it linear. Still, the notion of progression from a world dominated by the experience of a single subject to one characterized by interpenetrating subjectivities and the possibility of mutuality—a shifting, rather than a linear progression—remains appealing. En route to that goal, I think we hold, each in our own idiosyncratic way, whatever word we use to describe it. Let's complicate our understanding of holding's place in our work and let's honor its clinical function.

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REFERENCES


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