

## Holding and the Fate of the Analyst's Subjectivity

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*The constructivist/relational perspective has challenged the analyst's emotional superiority, her omniscience, and her relative removal from the psychoanalytic dialogue. It at first appears to be antithetical to treatment approaches that emphasize the analyst's holding functions. In this essay I examine the holding model and its resolution from a relational perspective. I propose that the current discomfort with the holding function is related to its apparent, but not necessarily real, implications. I discuss the analyst's and patient's subjectivity during periods of holding. I believe that the holding process is essential when the patient has intensely toxic reactions to "knowing" the analyst and is therefore not yet able to stand a mutual analytic experience. During holding, the patient experiences an illusion of analytic attunement. This requires that the analyst's dysjunctive subjectivity be contained within the analyst, but not that it be abandoned. Ultimately, it is the transition from the holding position toward collaborative interchange that will allow analyst and patient explicitly to address and ultimately to integrate dependence and mutuality within the psychoanalytic setting and thereby engage in an intersubjective dialogue. The movement toward mutuality will require that the analyst of the holding situation begin to fail in ways that increasingly expose her externality and thus her subjectivity to the patient.*

An important theme that prevades much recent psychoanalytic writing concerns the centrality of the analyst's subjectivity in the therapeutic process. This focus emphasizes the

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varied ways in which the analyst must make use of the self to be effective and always implies that the analyst herself is anything but an objective observer in this process (Casement, 1991; Jacobs, 1991; Fosshage, 1992). Here, psychoanalytic enactments are viewed as inevitable because neither patient nor analyst can, or should, exclude his or her subjectivity from the experience. It will be the working through of such enactments that is crucial to change. Mitchell (1991a, b), Aron (1992), and Burke (1992) underline the reciprocal aspects of analytic interaction. In this view of the psychoanalytic dialogue, patient and analyst engage collaboratively in ways that enhance the patient's self-understanding and that simultaneously tend to create a new, more mutual experience of the analytic relationship. Hoffman's (1991, 1992) social-constructivist view of the psychoanalytic setting underlines the centrality of the analyst's *uncertainty* and of her inability to 'know,' in any absolute sense, what the patient needs. Hoffman believes that the psychoanalytic dyad struggles together toward a deeper understanding even while both participants are continually aware of the power of their individual subjective experience.

The relational/constructivist position acknowledges the dissimilarity in patient's and analyst's experiences, but powerfully challenges the analyst's emotional superiority, her relative removal from the psychoanalytic dialogue, and her emotional omniscience. This perspective is enormously freeing for both analyst and patient and opens the possibility for more mutual contact between the two.

It is not particularly surprising that an emphasis on intersubjectivity should appear antithetical to treatment approaches that emphasize the analyst's parental holding function. This function has been articulated by a variety of theorists, including Spitz (1956), Sandler (1960), Mahler (1968), Little (1951), Khan (1963), Bion (1962), Bollas (1987), and, of course, Winnicott (1960b, 1963a, b). These writers emphasize the ways in which the patient's very separateness potentially represents a false self function to the degree that the patient feels required to split off core aspects of self-experience. The movement

toward a holding (and thus a less separate) position may allow the patient to turn over aspects of false self functioning to the analyst, and then to contact the true self (**Winnicott, 1960b; Balint, 1968**).

Winnicott was fond of noting that the holding process engages patient and analyst in a way that recreates aspects of the early infant-mother

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relationship. During holding, analyst and patient temporarily set aside several layers of reality in order to create a highly protective setting in which the patient's affective experience is not challenged by the analyst. A transitional space is created, allowing a therapeutic process to take place in a way that would otherwise not be possible.

Probably because of the tight connection that Winnicott made between holding and infancy, it is not altogether clear to what degree his and other writers' early descriptions of the analyst's protective function were meant to represent a metaphor or, instead, a temporary *reality*.

It is my thesis that the holding theme must be reexamined in a way that more fully addresses its metaphoric and relational components. From this somewhat expanded perspective, I believe that holding describes a core theme within all psychoanalytic treatment experiences. Although this dimension or thread of analytic process plays a central role with some patients and represents a minor theme with others, it is always present, as either figure or ground. In contrast to the idealized, nonconflictual picture that is often associated with holding, I believe this process to be characterized by a high level of emotional complexity for both patient and analyst that requires ongoing study and internal work. It is, I suggest, only if we retain the idea of *holding as metaphor* that we truly can make use of it while avoiding the reductionism implicit in a more literal reading of this treatment dimension.

Because I view the holding function within a relational perspective, I would describe holding to involve that dimension of psychoanalytic process within which the analyst *struggles* both to experience fully *and* to contain those aspects of her emotional reactions that are not conjunctive or reciprocal to those of her patient. The holding process allows the patient to feel received or contained emotionally while remaining unaware of aspects of her emotional impact. In this sense, holding processes permit the analytic object to remain subjectively perceived. During the holding process, the analyst *struggles* to provide an experience within which the patient is permitted to remain unaware of aspects of her impact on the analyst.

Although the holding process commonly has been associated with issues surrounding regression to dependence, the holding metaphor may also be used to describe key aspects of analytic process with self-involved or hateful patients. Holding may act to protect the patient's

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illusion of self-sufficiency (**Modell, 1975, 1976**) or to allow her to live with and integrate her intense feelings of hatred (**Slochower, 1991, 1992**). During these periods of treatment, the analyst functions in a way that protects the hyper-alert patient from the full impact of the analyst's separate subjectivity.

I do not view holding processes to exclude ongoing interpretive work. However, interpretations may disappear or temporarily recede in importance during holding processes insofar as interpretive interventions are felt to be impinging or destructive. Alternatively, interpretations may be used actively to support the analyst's holding of the patient rather than to expand the patient's self-understanding per se. That is, the patient may find a holding process *within* an interpretation itself.

## The Holding Metaphor and the Illusion of Attunement

The holding experience always involves a metaphor rather than simply a reality. Whatever its affective ambience, it describes the creation (by analyst and patient together) of an *illusion of absolute attunement* on the analyst's part. This attunement most centrally concerns the analyst's capacity to understand and evenly and consistently to respond to the patient's needs or feeling states. It is illusory because its maintenance requires that both parties temporarily bracket their awareness of the more complex aspects of the analytic interchange. Within that illusion, the analyst operates from a position of certainty. When the analyst chooses to provide the patient with a holding experience, it is because she "knows" what the patient needs. The patient cannot tolerate interpretation, needs a regression, or needs her self-involvement or rage to be held, that is, tolerated without direct interpretation or challenge. The holding analyst seems to function comfortably, intuitively, and without strain because of her enormous capacity to protect the patient from the noxious environmental impingement threatened by the analyst's separate perspective.

On first examination, this same illusion of attunement characterizes the holding analyst's confidence in her reparative capacities. The analyst's holding stance implies that she can provide what is needed—that

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she will be therapeutic in effect and sufficient to satisfy. It seems that there is little apparent room for doubt here—either about the analyst's emotional resources or about her conviction that holding is what is required. The illusion of analytic attunement suggests that the analyst's subjectivity is a virtual mirror of the baby's or child's emotional requirements. As a subjective object, the analyst-mother “allows herself” to be created and destroyed at will and suspends her own subjectivity when it is discrepant with this experience. In this sense, we may view the holding analyst not so much as *struggling* to meet the patient's needs, but instead as temporarily allowing the patient to appropriate her subjectivity (Ogden, 1992). As I make clear later, however, I believe struggle to be a pivotal element in the holding theme.

Nevertheless, to the extent that the analyst's struggle with the holding position remains internal, the holding process is likely to result in a temporary narrowing of the analytic play space, or of what Ogden (1994) describes as the analytic third, that is, the result of the meeting of the *separate* subjectivities of patient and analyst. The holding situation offers patient and analyst a somewhat limited third space to the degree that the patient is absolutely intolerant of the analyst's dysjunctive experience. Holding may be play, but it is play narrowly defined because the high degree of overlap between analyst's and patient's experience limits the possibility for truly mutual interchange.

I suggest, however, that even when the patient absolutely excludes the reality of the analyst's subjectivity, it is essential that the analyst retains, largely unexpressed, her capacity to imagine a movement toward an expanded analytic third.

The holding experience, then, of necessity contains an illusory component that is critical at moments for our patients, and perhaps also for ourselves. Mitchell (personal communication) suggests that such illusions are probably intrinsic to all intimate relationships. In a sense, illusions represent an antidote to or at least a caveat against absolute emotional authenticity. We do not always, for example, disabuse the patient of the feeling that he has “the best analyst in the city,” reminding him that he probably doesn't and in any case certainly will not always feel that way. Instead, we sometimes *do not* question, but rather accept, appreciate, and perhaps even share the patient's experience for the moment. In a similar way, when working with an attacking patient, at moments we may “hold” by accepting the rage without

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interpreting its sources, while also containing (rather than expressing) our own hurt or anger. In this situation, we allow the patient to experience the absolute validity of his rage and our unshakable capacity to tolerate it.

Elsewhere (Slochower, 1994, 1996) I have suggested that by creating this illusion of analytic attunement (based on the parental metaphor), the analytic holding function may permit the patient an experience of *object relating* in Winnicott's (1971) sense. During holding, the patient is not required to engage in mutual interchange because the analyst temporarily sets aside or protects the patient from her own subjectivity. Ultimately, however, the movement toward object usage will be necessary if the patient is to acquire a more solid, less reactive capacity for collaborative intersubjective dialogue. The evolution of such dialogue will take place as the patient becomes more able to tolerate and integrate the analyst's externality, unreliability, and her failures, and thus increasingly is able to experience the analyst's subjectivity as enriching rather than impinging. For some of our patients, the holding phase of treatment may be an essential although probably never a sufficient step on the way toward a fuller integration of object usage and mutuality.

Winnicott seemed to view the holding experience as a treatment phase that ultimately would give way to the evolution of object usage. I suggest, however, that the acquisition of object usage will not ordinarily result in the disappearance of issues associated with object relating and the need for a holding experience. Even as the patient begins to experience the object confidently as both resilient and responsive, the analytic process still periodically moves both forward and backward between object relating and usage. In addition, issues related to object relating and the need for holding occasionally may turn up with patients who have largely integrated a capacity for object usage. In this sense, holding represents a dimension or thread of analytic experience that plays a core role with some patients and is a background factor with others.

## Holding and the Relational Critique

The implicit idealization of the analyst's position within a holding context (Tansey, 1992) appears markedly incongruous with a constructivist/relational

perspective. Whereas Bollas (1987), Bromberg (1991), and Casement (1991) have included the concepts of both mutuality and dependence in psychoanalysis, many take issue with the implications of the holding models. In fact, Winnicott and others who emphasize the patient's dependence on the analyst's maternal functions have been criticized for their positivist, quasi-authoritarian perspective. Mitchell (1988) questions the idealized position in which the analyst-mother is placed by "developmental tilt" models, and notes that the patient is consequently infantilized. He further suggests that these models sidestep the question of whether the patient's *wishes* (conflicts) or her *needs* (deficits) are the central therapeutic issue (Mitchell, 1991b). Aron (1991) believes that the "analyst as holder" deprives the patient of a complex and adult type of intimacy. Stern (1992) points out that the analyst-as-mother has limited freedom, and that her patient will be similarly restricted. He notes that the patient-baby metaphor implies that the patient is relatively unable to "see" the analyst in ways that are inconsistent with the empathic, mothering position. From the baby perspective it is difficult for the patient to communicate such perceptions to the analyst. The resulting therapeutic interchange will thus be one that addresses only a rather circumscribed area of exchange between the two.

Can the social constructivist critique of the maternal metaphor be reconciled with the notion of analyst as holder? Because the patient is not a child and the analyst is not the mother, the emotional experience of both parties often will be more complex (and more problematic) than that of parent and child. Certainly, if the analyst provides the patient with a holding experience from a position of absolute emotional certainty about her patient's needs and about her own desire and capacity to give, both analyst and patient will be forced into a rather narrow and rigid relationship with one another. In this sense, the maternal metaphor never can describe altogether the totality of either patient's or analyst's experience. Nevertheless, I believe that if we absolutely embrace the notion of mutuality within analytic process, we may fail to identify its limitations.

It is my conviction that the constructivist/relational perspective, although pivotal to the treatment process with many patients, does not address treatment issues raised by those clinical contexts in which the patient cannot *bear* to know the analyst and finds mutuality noxious. I

view this perspective to contain an idealization of mutuality that potentially is problematic in ways similar to the notion of the idealized holding analyst.

The constructivist position implies that the patient often already "knows," but cannot tell, because of her own personal historical constraints and because of the analyst's resistances to being seen. It assumes that the patient always will be both relieved and helped if the analyst allows for mutual interchange. In this sense, the constructivist/relational position assumes that the patient has *already* achieved object usage, or in other words is capable of working with and integrating the sometimes marked contrasts between her subjective experience of the analyst and the analyst's external, "objective" existence. Given a patient's solid capacity for object usage, collaboration and mutuality represent enrichments rather than threats to the analytic interaction.

But what of those for whom object usage is elusive? Some of our patients are a long way from object usage, that is, from being truly capable of tolerating the analyst's subjective presence and thus also a clearer sense of aspects of their own impact. Instead, mutuality and intersubjective interchange may present a genuine and powerful threat. Whereas many of my patients respond to evidence of my own subjective presence in ways that dramatically open up the treatment process, for other people and at other moments, this same subjective element derails us. *It is precisely when intersubjectivity and mutuality are problematic that the holding metaphor offers a crucial therapeutic alternative.* Unfortunately, some relational theorists view this metaphor to be inextricably associated with a model within which the analyst is seen as complacent, omniscient, potentially authoritarian, and defensively out of contact with her own (dysjunctive) subjectivity as she infantilizes her patient. In contrast, I believe that the holding process is in fact compatible with an intersubjective psychoanalytic position.

I suggest that the current focus on analytic mutuality fails to address the treatment issues raised by those patients whose emotional experience requires that, temporarily, the analyst *not* be known. I view the apparent suspension of the analyst's subjectivity to represent a paradoxical aspect of the holding experience, because it is therapeutically necessary for the patient, yet simultaneously illusory. During moments of holding, the patient must temporarily be protected from those

aspects of the analyst's experience that would put into question the reality of the analyst's attunement. These primarily involve the analyst's own subjective, and especially her dystonic, responses, as well as her doubts about the holding process itself. Both of these will be impossible to address until the power of the analytic holding experience has subsided.

For many patients, the relational experience represents a hard-won analytic achievement that parallels the transition from the analytic holding environment and from object relating toward a capacity for collaboration. When holding gives way to an increased possibility for collaboration (or for object usage in Winnicott's [1969] sense), a new level of interchange is evolving that will allow analyst and patient explicitly to address and ultimately to integrate dependence and mutuality within the psychoanalytic setting.

## Containment and the Analyst's Subjectivity

Not surprisingly, Winnicott's notion of regression to dependence and holding are associated with a Renoiresque image of the analyst-mother, gratified by her capacity to give and to be evenly available to her patient-child. Superficially, the analyst-mother metaphor does suggest that the patient is a passive recipient of good-enough care, and that the analyst functions in a comfortable, *even* way as maternal provider. The analyst-mother may, in this sense, be viewed as an empty container, ready and willing to receive the patient's experiences. In fact, a central fantasy that dependent patients often express during periods of holding involves precisely this idealized version of the analyst.<sup>1</sup>

I have been working for some time with Sarah, an extremely vulnerable patient who is ongoingly sensitive to even small variations in my emotional presence. Our work has alternated between periods of dependence and moments—or even some longer processes—during which Sarah engages with me in a mutual analysis of both historical and transference issues. During the latter exchanges, I have felt free to be fully myself. Yet these moments often lead to the uncovering of

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<sup>1</sup> See Slochower (1996, *in press*), for fuller discussions of the evolving maternal metaphor and its treatment implications.

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some especially painful material, which in turn heightens Sarah's sense of vulnerability, and her need for holding. It has been quite clear that Sarah's capacity to integrate and make use of our work largely depends on my capacity to provide a reliable holding presence. Sarah made the centrality of the illusion of my attunement quite clear to me. During one such holding phase she said to me, "You are always *with* me. I count on that. This is the only place in my life where I am safe, and what makes me feel safe is that I know that you don't let me down." When I questioned this (I think I said "Really, never?"), she replied, "Yes, never. Even when you get it wrong it's not by much, and you stay here until you get it right."

Was this true? Was it possible, no matter desirable? It is noteworthy that Sarah's description of me often, but not always, fits with my own emotional experience of sessions. Conversely, there are moments during which I feel like anything but an evenly reliable analyst. I am also aware that I often feel quite tired after her session, no matter what time of day it occurs. In this sense, my work with Sarah actually involves considerable strain. The strain surrounds a feeling that I almost cannot move or breathe during our sessions, that I need to stay very close, both literally, by sitting forward in my chair, and by being absolutely present emotionally. I seem to sustain a holding stance by largely, although not entirely, excluding the experience of strain during the sessions. Between our sessions, however, I find myself struggling with markedly incongruous feelings and thoughts. These thoughts are troubling. How far will this go? How much will be asked of me? Am I gratifying my own need to be seen as a good parent or is this position a genuine therapeutic requirement? The exhaustion I feel later and the questions I am left with about the process indicate that I succeed in partially postponing an awareness of my subjectivity during the actual session, rather than in altogether deleting it from the holding experience.

This should not be particularly surprising. Kraemer (*in press*) notes that the mother remains susceptible to subjective internal processes during her child's babyhood. Because, as Mitchell (1988) underlines, the patient is *not* a baby, the analyst surely is still more likely to remain a subjective presence.

I would argue that the analyst who offers the patient a holding experience involving an illusion of attunement is *inevitably* under considerable

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strain. This strain involves two discrete elements. First, the analyst must attempt evenly to receive and to tolerate the patient's intense and sometimes difficult emotional states. Second, the analyst struggles, perhaps even more powerfully, to contain aspects of her *own* subjectivity, and thus at least partially to protect the patient from them. Although the analyst's response to



the patient may primarily involve maternal, nurturing feelings, it is more likely that the analyst's reactions to patients needing a holding response will be complex.

Maintaining a holding stance requires a level of attunement that is both deeply satisfying and exhausting. I often struggle with the desire to break into the holding process and thereby to assert my subjectivity, to be acknowledged as real, human, and fallible. Although I can feel enormously gratified by my patients' positive reactions to a sensitive response during periods of holding, at times I also feel required to walk too thin a line—never to be tired, distracted, momentarily self-preoccupied, nor permitted even a temporary escape from the pressures of the holding position.

At moments like these, an explicitly relational perspective would be enormously relieving. It would allow me to say, in essence, “Hey, there are two of us here, remember?” Yet my experience has been that there are moments when *any* clear indication of my autonomous existence is profoundly disruptive.

During the past winter I developed a particularly bad cough, although I otherwise felt fine. For many of my patients, my cough was a cause for either concern (how sick was I?) or irritation (it was distracting and annoying). With these patients it was quite possible for my presence, disruptive though it was, to be acknowledged and directly dealt with. For Sarah, however, the cough produced quite a different reaction. She spoke with increasing hesitancy as the session progressed, becoming silent when my coughing interrupted her. When, after some minutes of silence on both our parts, I said quietly that it was clear to me that she was having trouble either ignoring or responding to the fact that I kept inadvertently interrupting her, she began to weep convulsively, unable to speak for many minutes. Finally, she said, simply, “There is no room for me here.” She could not hold on to the expectation that I would soon be better, be angry with me for impinging on her experience, or be concerned about me. At that point in the treatment,

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my holding function was so pervasive that its disruption had an unhinging effect that lasted for some time after I had recovered.

Despite several attempts on my part, Sarah made it quite clear to me that she could not talk about the session in a useful way, and instead needed to return as quickly as possible to the feeling of being soothed by me. It was not until the period of acute dependence had passed that Sarah was able to talk about her own experience during that session, and of her distress at evidence of my misattunement.

At times I struggle with a variety of responses to Sarah's ongoing need for a holding experience. Should I, for example, have canceled her session that day, anticipating her reaction to my coughing? Why *did* I choose to see her? To what extent did I act out of self-interest (wanting the income), anxiety (my awareness that she would feel disrupted and distressed were I to cancel), or concern (about maintaining the delicate state she is in)? How angry am I at her intense need or neediness (**Winnicott, 1947**)? Have I disavowed my own subjectivity for too long? I would be enormously relieved were I able to be momentarily unreliable, to be free to respond less carefully, to *not* respond, or even to say, for example, that I do not feel well that day. When I feel required to contain these experiences fully, an added dimension of tension enters and remains in the psychoanalytic setting.

## Holding Self-involvement and Hatred

Elsewhere (**Slochower, 1991, 1993**) I have discussed the application of the holding theme to a variety of treatment and real-life situations where a holding response to the patient's self-involvement or hate seems to be therapeutically pivotal. Here again, the primary function of holding is to provide a reliably protective setting within which difficult feeling states can be experienced without the patient's being required to respond to the analyst as a discrete other. Whereas my earlier discussion of variations in analytic holding processes emphasized the relationship between different kinds of patients and the holding experience they require, I have come to feel that there are also moments with a *single* patient during which different kinds of holding processes may be needed. Even a patient whose primary issues involve vulnerability and

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dependence may, at other times, present with a rather narcissistic oblivion or even with veiled (or not so veiled) attacks on my adequacy in a way that seems to require a holding response. In this sense, it may be necessary for the analyst to cope with a wide range of subjective responses to holding work with a single patient.

To tolerate a patient's hateful attacks or narcissistic obliteration will not leave the analyst in a position to respond seamlessly, in a containing way. Yet, like patients in periods of intense dependence, self-involved and rageful patients

sometimes indicate quite clearly that they have little tolerance for the analyst's separate subjectivity.

An extremely self-involved artist patient returned from a vacation and quite characteristically described in great detail what she had accomplished that month. Toward the end of the session, she paused and said "Why am I telling you all this? I just want you to listen. I don't really want you to say anything at all. It's like I want to hear *me*, not you." When I asked her whether she really wanted to know what I thought about her experience of me, she paused only briefly. "No way. One way or the other, you'll try to change something about me, and I only want you to know."

As this very articulate patient made clear, her experience of susceptibility to influence was such that any explicit indication of my separate perspective was quite threatening. I have found it to be more common for patients struggling with issues of narcissism or rage to be unable to articulate this danger in a clear way. Yet it is sometimes evident that they are not helped by my attempts to introduce myself into the process, either directly or via interpretation. Attempts, for example, to address a hateful patient's impact on the analyst may lead to an escalation in the patient's attacks, probably out of the patient's unconscious fear and testing of the destructive potential of these attacks.

In these situations, it is most tempting to break into the patient's rages or self-involvement with interpretations that actually function as disguised attacks (Epstein, 1979, 1987). The purpose of such attacks is to rid the analyst of the intense rage and/or helplessness that tend to be evoked when one is subjected to an ongoingly tense analytic situation. It is similarly close to impossible to retain a position of conviction about the therapeutic efficacy of a holding process in these treatment situations. Instead, holding here involves the analyst's containment of self-doubt

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about her own competence and about the treatment process itself (Slochower, 1992).

## Tolerating the Holding Environment

It appears, then, that the analyst who attempts to provide the patient with a holding experience is in a particularly tight spot emotionally. To the degree that the analyst's subjectivity is all too present, the requirement that the patient be protected from it represents an added emotional dilemma. At times this strain may result in unconsciously motivated disruptions of the analytic holding process. In contrast to the sometimes useful effects of the analyst's unreliability and subjectivity during "ordinary" work, these disruptions, while inevitable, represent genuine impingements on the patient during periods of holding.

After some weeks of intense dependence on Sarah's part, feeling rather pressured for a variety of reasons, I scheduled a meeting with a colleague during Sarah's session time. I was aware that I would have to cancel or reschedule Sarah's hour, but somewhat guiltily decided that it would be all right because she would be able to see me later that day, whereas my colleague would not. I did, in fact, easily reschedule Sarah's session for the early afternoon. Although I of course should have anticipated this, Sarah's intense distress took me by surprise. She was not so much hurt as disoriented; this disorientation lasted for over a week and was quite severe. Sarah's recovery was gradual, in very much the way that Winnicott (1964) described his vulnerable patient's reaction to his own idiosyncrasies.

Why did I "act out" and introduce this disruption into Sarah's analysis? I did so knowing quite clearly that I deliberately chose my own desire over hers. I was not, however, fully conscious of the likely effect of my actions (my feeling of guilt should have, but did not, signal this to me). While one could speculate that this action involved an unconsciously motivated retaliation for the level of pressure I was feeling, I am inclined to view my behavior as more complexly motivated. In retrospect, it seems to me that I made this request in an unconscious attempt to renegotiate with Sarah the limits of my availability. I could no longer tolerate fully bracketing my subjectivity in the context of our

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work. I had had enough, and despite my intentions to the contrary, I rebelled against an ongoing experience of pressure and thus alerted both Sarah and myself to the limits of my own emotional attunement. In doing so, I reopened our dialogue around the issue of our respective needs, and in this sense, I broke into Sarah's holding experience.

In one way, this renegotiation was crucial in allowing me to maintain a holding position with Sarah. In the absence of any possibility for negotiation within the analytic relationship, it seems inevitable that the analyst's ability to maintain a therapeutic holding stance would break down, perhaps dramatically. Although it is possible that these experiences were somehow strengthening for Sarah (in that she ultimately did go through them with me and survived), my sense is that she paid too high a price and was far too unhinged for this possibility to represent more than a rationalization on my part. Sarah's

traumatic responses to this experience contrasted with the rich and varied uses that many of my patients make of such incidents, which expand and deepen their awareness and expression of feelings about our relationship.

In hindsight, it seems surprising that unconsciously motivated disruptions of the holding process do not occur more often. Why not? How does the analyst tolerate keeping herself out? The analyst requires a considerable capacity for self-protection if she is to maintain a holding stance in a way that does not ultimately result in disaster.

I automatically maintain rather clear boundaries around analytic sessions, especially with my patients who need longer holding experiences. These boundaries delineate my time constraints literally and also subtly, probably in partially unconscious communications. The effect of these boundaries is to limit my attunement to what I can tolerate. In addition, these boundaries establish evidence of my own idiosyncratic presence. This process is largely subtle and symbolic. It involves the assertion of my subjective presence and implicitly establishes the limits of my willingness to adapt.

I offer a particularly concrete example. Some years ago I became aware that I felt irritated on wet days when some of my patients did not use my floor mat to wipe off their shoes and tracked mud on my rug. After some internal struggle I decided to ask people to leave their wet boots in the hall on bad days. I was aware that this was an unusual request, but after some initial apprehension about people's reactions, I

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found that I felt relieved and no longer uncomfortable working on those days. Of course, more than one of my patients (interestingly, always those *not* involved in a holding process) has articulated a reaction to this request. Most typically the feeling is that I am excessively fussy about my home, and that I am asking my patients to accommodate me in this fussiness. In a way, I agree. It seems to me that this perhaps insensitive request symbolizes for me the reality of my subjective presence, and serves as a measure of self-protection. It is as if I say to the patient, "In this way, at least, you can't mess up my space. I have one foot in a separate world, and I intend to keep it there." The explicit or implicit establishment of one's subjectivity is probably what allows the analyst to tolerate this work in general, and perhaps most especially with patients requiring a holding experience. I imagine it is always necessary that the analyst make this statement (to herself, and probably sometimes also to the patient) either concretely or symbolically. It is absolutely crucial that it be made if the analyst is to undertake and tolerate holding work.

## Negotiations Around the Holding Process

The holding metaphor describes a discrete emotional state that may be momentary or more ongoing. It stands in marked contrast to the patient's experiences when a holding process is not required. What, then, of those patients who remain on the perimeter of the holding experience, who toy with the possibility of even a brief moment of dependence on the analyst, but who are simultaneously rather skittish and quick to withdraw at any evidence of the analyst's misattunement? With some people I have found that a single interchange suddenly becomes a test of my attunement—if I "pass" it, we move rapidly in the direction of a holding process. I had such an experience with a very schizoid patient who called me one day to ask for an extra session because of something that had upset her at work. I gave her an early morning hour. She guessed (correctly) that I did not ordinarily work at that time. This meant to her that I could, in fact, be counted on, and she rather rapidly moved in the direction of allowing both of us to see the depth of her vulnerability and need.

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With other people, however, my attunement is not so easily assessed. For individuals whose central struggle involves issues of dependence, the testing out of my capacity to be sufficiently responsive often leads to failure. Our negotiations around these failures become an ongoing and sometimes apparently endless process that involves moments of holding as well as moments in which my subjectivity is more explicitly present.

I have been working for some time with John, a patient who has recently begun to articulate both his longing for and his dread of needing me. Both of these states tend to result in a sense of rage at my misses or failures and are followed by long periods of anger, disillusionment, and attacks on me. At the end of one session that felt rather close and easy (and thus perhaps uncomfortably near to a regression to dependence) I (as usual) sat forward in my chair to signal that I was about to end the session. John reacted by looking at his watch and loudly stated that our time was *not* up. Slightly puzzled, I checked my clock and watch again, silently noting that according to my timepieces, the session was over.

Here then, we were once again on the edge; John's challenge regarding the treatment boundary placed at the center of our dialogue a multitude of issues regarding my willingness to adapt to him and the potentially disruptive effects of a break in the



holding experience. The dilemma was rather dramatically clear-cut: Whose clock would I go by? Who got the disputed minutes? On one hand, I wanted to “prove myself” to John, to reassure him of my holding potential. On the other, it was impossible for me to ignore the degree of accommodation that this required of me; the tension between my perceptions and needs and John's was absolute.

It was not unusual that this predicament occurred at the end of the session, when there was literally no time. As I tried to find space within which to work, I was aware of a combination of thoughts. I was somewhat pressed for time, having a heavy schedule and a patient already waiting for me. The obvious, and in some way easy, response would be to articulate John's desire for more of me and his anger and hurt at my “stealing” from him, or more implicitly rejecting him. I was acutely aware, however, that to interpret John's protest or his wish would feel horribly humiliating to him.

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I thus felt in a bit of a bind. Should I insist that I was right and disregard his implicit request for more time in order to protect my own needs? Should I continue the session for a few minutes and set aside my subjectivity? What of my “objective” perception that we *had* both started and ended on time according to my own clocks? What would he make of my giving up my subjectivity in the face of his protest? What would *I* make of it? I struggled briefly with my wish to meet both his needs and my own. Finally I said, “According to my clock, which may or may not be accurate, we started and ended on time, so I feel it's time to end. I understand that it may not be time from your point of view.” John sat up, looked ironically at me, said firmly, “It's *not* time,” and left.

I was a little apprehensive about the effect of this interchange. I hoped (rather wistfully) that John had heard my acknowledgment of the reality of both of our subjectivities in the context of my taking the prerogative to end the hour. I was concerned, however, that I had had too greatly disrupted John's tentative moves toward closeness by introducing my externality at that moment. In fact, our negotiations around my attunement and lack thereof have continued from session to session and sometimes from moment to moment. John ongoingly both longs for and fears the exposure involved in a holding experience around dependence. I have the sense that this will not be possible until he has developed sufficient confidence in my capacity simultaneously to retain a sense of his subjectivity and of my own—of my ability both to respond and to “hold the line.” In this sense, our negotiations *around* the holding experience may well constitute the bulk of our analytic work.

For a complex of reasons, in this situation I moved out of a holding stance and intervened with John from a somewhat more separate, intersubjective position in that I neither bracketed nor deleted my subjective experience and need. Why? To what degree was my response reactive to what John could tolerate? The fact that John presented his need in a challenging rather than vulnerable manner certainly made it easier for me to hold my own, because he implicitly showed me something of his own resilience. Additionally, however, John challenged me around an area that I use to express my subjectivity (I do tend to keep to firm time limits). In this sense, my movement

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away from a holding position was simultaneously influenced by the press of my own subjectivity and my sense of what John could tolerate.

The holding position *must not and probably cannot* dominate the analyst's work in a uniform way, but instead must remain a choice or alternative. The movement in and out of a holding stance inevitably is affected by a mixture of factors that include the patient's need, the analyst's perceptions of that need, and the analyst's own subjective experience.

## **Paradox: Illusion, Certainty, and Subjectivity**

The analytic holding process involves an implicit paradox. Although the patient is not a baby and the analyst is not the parent, both parties partially may suspend their awareness of the illusory nature of perfect analytic attunement for a time. That awareness, however, hovers at the edges of the analytic experience, occasionally breaking into our contacts. Yet it is simultaneously clear that explicit evidence of the analyst's misattunement (i.e., separateness), whether through unconsciously motivated analytic interventions or through the inevitable unreliability of the setting itself (e.g., vacations and other interruptions), may in fact be profoundly disruptive during certain periods. These disruptions once again underline the temporary *reality* of the patient's need for a high degree of adaptation and emotional resiliency on the analyst's part. With most patients, this highly reactive state will be a transitory one that will alternate with, and ultimately give way to, a more complex and mutual level of relatedness.

A question raised by the paradox of the holding metaphor concerns when, and how, one “knows” that what is needed is a

holding experience. Does the holding function arise spontaneously and seamlessly on the analyst's part in response to the patient's need? Does holding involve a more or less objective (positivist) assessment of the patient's emotional state, or does holding emerge out of the inherently subjective, negotiated interaction between patient and analyst? That is, does the analyst who holds *choose* to do so, or is the holding process or moment relatively organic, developing naturally out of the analytic interchange?

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I view the movement toward a holding stance to involve an inherently paradoxical interweaving of the apparently objective and subjective elements in the psychoanalytic holding situation. Simultaneous with my feeling that I choose to hold is the sense that I have, in fact, no choice except to hold! The relative weight of these two elements fluctuates as a function of variations in the analytic interaction.

The decision to hold always requires that the analyst study what she “knows” about the patient. How is the patient responding to the analytic interaction? What does she seem (both consciously and implicitly) to need? Unless I am temporarily in the throes of an intense counter-transference reaction to a patient, I believe that I can often hear the central thrust of her communications. In this sense, the movement toward an analytic holding stance in part represents a conscious, deliberate choice on the analyst's part. This choice entails the analyst's assessment of the patient's emotional state and of her issues (conflicts) as well as of her needs.

If my patient's responses indicate to me that she consistently reacts violently to evidence of my separate personhood, or to my even slightly discrepant emotional experience, I will begin to question the nature of our interaction. Several possibilities emerge here. It may be that the source of my patient's difficulty involves what I have interpreted, or the way I have done so. Alternatively, it may be that the patient's own conflicts around recognizing some aspect of our mutual interaction are interfering, and that further exploration of these issues will open up the process. It is clearly impossible ever to be absolutely sure that holding is the only appropriate therapeutic choice. Nevertheless, when my patient's toxic reactions to evidence of my separateness and her vulnerability to emotional “misses” have a consistently adverse effect both on our work and on her outside life, I am likely to move toward a holding position.

Yet it is simultaneously clear that my decision to move toward a holding stance is always made under the impact of subjective factors. My sense of the patient's relative vulnerability, of the force of her need, her anger, her reactivity to impingement, will always be informed by my own emotional experience of her. Do I feel like holding? Do I feel shut out of the analytic interaction? Am I aware of the desire to insulate myself from my patient's anger? The more powerful my subjective

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response to the patient (whatever its particular color), the more likely I am to feel “forced” to choose to hold. These dilemmas are cogently discussed by Mitchell (1991a, 1993), Shabad (1993), and Ghent (1993).

In an earlier essay (Slochower, 1991) I discussed the analyst's subjective response to offering a variety of holding functions (i.e., of dependence, self-involvement, or ruthlessness and hate). The subjective elements involved in these diverse moments are quite different.

The analyst's responses to dependent patients are perhaps simultaneously the simplest and most complex of the variety of my experiences during periods of holding. The patient in need of a regression who is able to move beyond neediness and to express need (Ghent, 1993) is likely to leave the analyst in a reciprocal emotional state. From this parental position, holding “feels right.” The holding position does not seem to require much thought. Of course I can, if asked, articulate the patient's need to experience previously split off or hidden vulnerability, her sensitivity to my responses to her, and the positive therapeutic effect of a holding stance in allowing her a fuller experience of herself. Nevertheless, to the extent that I see myself as choosing to hold, I probably am partially unaware of the powerful, mutual emotional pulls that are being communicated by the patient and by myself. My holding response has emerged spontaneously out of a complex of communications on my patient's part, some of which I did not even fully register. The apparent seamlessness that characterizes it is central to issues of dependence, because by definition holding here requires that I temporarily set aside my dysjunctive subjectivity. To the extent that this process represents an enactment of our reciprocal experiences, it will not be possible for us to sketch out the multiple meanings of the holding experience until its intensity has subsided.

My subjective experience is quite different during those periods of work when a self-involved or angry patient seems to need a holding response. Here, the patient's difficult self-presentation does not elicit an organic, reciprocal parental response.

To the extent that I feel like a parent, I find myself attempting to manage my patient's self-involvement or rage and my responses to it. Interestingly, the analytic holding position will allow me to make use of some of these subjective responses—by *keeping out* with the self-involved patient, and by responding with a matter-of-fact, modulated anger with an angry

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patient.<sup>2</sup> In fact, holding in these contexts always requires that I *hold myself*, that is, *hold onto* my rather complex emotional responses to my patient. With these patients I am intensely aware of and involved in an ongoing struggle to retain some sense of confidence in the efficacy of the analytic work. At times, this requires some tenacity. This internal holding stance is necessary because of the ongoing absence of any clear evidence of therapeutic movement with these very difficult patients.

Yet even with more difficult patients, the holding process may seem from the outside to be far more organic and nonconflictual than it is. It thus appears that the holding metaphor, like much of psychoanalytic process, is characterized by paradox (Ghent, 1992; Pizer, 1992). Although it is certainly true that the analyst is in fact incapable of complete emotional attunement, and further, is rarely in a position fully to “know” what to do, both parties suspend this piece of awareness for a time, behaving “as if” it were not the case. The illusion of attunement—an illusion that patient and analyst share—reflects their confidence in the analyst's reparative powers. Yet it is only the deluded analyst who enters any kind of holding situation with absolute confidence about its therapeutic efficacy. To the extent that the analytic holding environment is functioning in a therapeutic way, and does not represent a *folie à deux* between analyst and patient, the analyst (and, at moments, the patient as well) retains the capacity to acknowledge the paradoxical nature of the holding metaphor even while it is experienced as simply real. It is therefore the use of holding as *metaphor* that is therapeutically pivotal. When that awareness breaks down, so may the holding process, because both patient and analyst lose the capacity to retain potential contact with their (bracketed) subjectivities.

## Patients' Responses to the Analyst's Subjectivity

I have found that when patients are involved in a more “ordinary” or mutual level of psychoanalytic interchange, my emotional variability will, unless extreme, either go nearly unnoticed or will be responded to with a directness that allows it to be explicitly addressed. As Aron

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<sup>2</sup> See Slochower (1992) for fuller detailed clinical description of such a treatment.

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(1992) and others have so clearly elaborated, when the analyst's subjectivity is addressed, the resulting interchange often deepens the patient's experience both of herself and of our relationship to one another. Whereas patients may have quite a variety of reactions to evidence of my own subjectivity (including anger, pleasure, and frustration), their struggle with it and with me is most often strengthening and ultimately results in a freer level of interchange between us.

With patients during moments of holding, however, my variability is more often traumatic than helpful. During these moments, the psychoanalytic interchange is not as yet characterized by mutuality. Real mutuality within the treatment context would require that the patient be relatively able to tolerate the potential impingement that is always threatened by the analyst's subjectivity.

Does the analyst's containment of her subjectivity imply its absence for the patient? This is usually not quite the case. During periods of holding, patients themselves often have at least a peripheral awareness that I have more complex feelings about our relationship (and am a more complex person) than they are quite prepared to assimilate. In this sense, I am suggesting that disruptions *will* inevitably occur even during a holding process. The patient's need for a holding experience, however, allows or even requires that she *exclude* its dysjunctive elements.

Thus, a rather schizoid patient who entered a phase of intense regression following a very long and somewhat intellectualized period of self-analysis recently told me, “I imagine that it must be hard for you to stand this—to have to be so absolutely available to me. I even think that you might be mad at me sometimes because I react to every little shift in you. I don't want to know, though. I need you to just *be* this way, to keep *you out* at least for now.”

It seems quite clear that the absence of mutual interchange did not in fact mean that I was devoid of subjectivity either from my patient's point of view or from my own. Instead, my patient asked that I temporarily set aside these desires in order to provide a containing experience for her. It seems inevitable that this requirement will leave the analyst feeling both comfortable and strained by the patient's intense reactivity. In fact, when the analytic holding function predominates, both

analyst and patient temporarily suspend their engagement in interchange around the *analyst's* subjective experiences. Although this

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suspension may lead both members of the dyad to an authoritarian, grandiose, and/or idealized view of the analyst's function, it is also quite likely that both know better.

The analytic dyad does not often enter a holding experience easily or seamlessly. Paradoxically, this apparent seamlessness both exists and is simultaneously illusory. That is, a negotiation between analyst and patient does take place around the holding process. This negotiation is, however, almost always tacit, never explicit. For a holding process to take place, the patient cannot challenge the boundaries of the analytic holding experience; instead, patient and analyst implicitly agree not to question the analyst's largely good intentions, her emotional resilience and attunement, or her capacity to hold. Yet the patient makes clear, through both conscious and unconscious communications, what is essential for *her* during the holding process, and the analyst also inevitably asserts the limits of her capacity to sustain this stance. In my own experience, these negotiations around both participants' needs and limits remain largely unarticulated in a direct way with the patient during holding. This tacit negotiation stands in marked contrast to the explicit bargaining that often takes place with patients who are engaged in more mutual analytic interchange.

## Analytic Holding, Object Usage, and Mutuality

Although I have argued that a crucial treatment dimension often involves a holding experience within which the therapist maintains a containing position vis-à-vis the patient, this process alone is rarely therapeutically sufficient. I understand the analyst's holding function to describe *one* dimension of analytic process rather than its totality. People come for treatment suffering from a painfully limited capacity to experience the self, and from a related narrowing of experience with objects. It is thus critical that the therapeutic process addresses the patient's experience of the *object* in conjunction with an elaboration of the self. Not until the patient can tolerate the analyst as a separate, alive presence can a mutual interchange be integrated in a useful way by the patient. This dimension is addressed by intersubjective dialogue and not by holding. That is, the movement toward collaboration with

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the analyst as a separate subjective presence will effect this shift. I use collaboration to describe the patient's willingness and capacity to work with two separate sets of subjectivities, and to address and work with her emotional responses to the analyst's input when it is discrepant with her own experience. The acquisition of a capacity for collaboration is the pivotal factor that facilitates the emergence of truly reciprocal interchange within the analytic setting.

Collaboration implies the achievement of what Winnicott (1969) called object usage. Winnicott did not fully spell out the relationship between the holding experience and the achievement of object usage. However, elsewhere (Slochower, 1994) I have suggested that it is the analytic holding function that will allow the patient to experience the analyst as a subjective object, that is, to become involved in *object relating*. By the analyst's maintaining an emotionally protective, nonintrusive position, the patient is largely protected from the full impact of the analyst's quite distinct otherness. Holding alone cannot address the patient's difficulties with objects, because holding does not require that the patient sift out the projected from the real aspects of the analytic object. Although holding helps the patient to recontact and to integrate splits in *self*-experience, it does not explicitly address splits in object relationships. Most important, holding excludes the integration of the patient's hate with her love for the analyst and does not allow for a mutual level of interchange.

For this reason, the holding experience simultaneously represents a crucial and yet an unsatisfactory level of contact. It is unsatisfactory in two different ways. First, the holding process leaves the patient very much at the mercy of the analyst's ability to respond "just right." This level of emotional reactivity is difficult for both patient and analyst, and cannot be tolerated indefinitely. In addition, during moments of holding, both patient and analyst are deprived of the richness that is available only through a fuller and more mutual "knowing" on the patient's part. Until patient and analyst can relate in a way that includes the patient's awareness of the analyst's external existence, their relationship might be characterized as an "unconcerned" and a rather limited one.

The shift from holding toward collaboration will permit some expansion in the complexity of the analytic interaction. This transition involves the patient's increased capacity for concern, which in turn

implies the integration of love and hate for the analyst (**Winnicott, 1969**). Collaboration also requires a capacity to tolerate and to enjoy *difference*. It thus implies that the patient can sustain a secure awareness of the object's autonomous existence and of the patient's capacity for loving and hating without threatening the object's survival. As Winnicott noted, object usage will allow the patient to place the analyst outside the area of the subjective object. Only when the analyst is allowed her own separate reality can the patient tolerate fully collaborative intersubjective experience.

When the patient in a holding process moves toward object usage, the treatment focus shifts from the work of contacting and addressing split-off aspects of the self to that of integrating and differentiating the patient's experience of the object, and especially of the analytic object. For this to take place, the analyst *must* become both explicitly real, vulnerable, and momentarily misattuned. What is central to the evolution of object usage and collaboration is the analyst's willingness to tolerate alternately being experienced as a real, external object and as a subjective one. During the move toward object usage, the analyst is potentially vulnerable and yet capable of retaliation. As the patient's capacity to fully "take in" the analyst evolves, the analyst's resilience as well as her reactivity will be tested by the patient. This testing involves the patient's tentative and ultimately all-out exposure of her love and hate for the analyst, and thus will always depend on the analyst's response. Implicitly, therefore, when the patient moves toward object usage, she is testing out the viability of an intersubjective experience.

Most discussions of object usage have tended to imply that usage evolves smoothly, almost seamlessly, out of a good experience of object relating (see **Newman, 1984**). I view this shift to be anything but spontaneous, involving instead a complex interplay between holding and failures in holding—that is, between the patient's sense of the analyst as objective and subjective object.

When patients move from object relating toward object usage, my existence as a separate, imperfect, potentially vulnerable, *and* retaliatory object becomes a central focus. In Ghent's (**1992**) apt description, during the transition to object usage the patient engages in intensive object *probing*. Whereas during holding, the patient is likely to react to my empathic failure or to evidence of my external existence by withdrawing or attempting a repair, the evolution of object usage involves

the patient's emerging capacity to see, love, hate, and ultimately tolerate my separate existence in the context of our connection. It is only from this point in the treatment that true mutuality will be possible. Even here, holding and object relating do not disappear as treatment themes, but instead become increasingly background elements that occasionally will reemerge with some force.

After several years during which Sarah's treatment often involved a holding process, she slowly began to show some evidence of a growing capacity to tolerate both my subjectivity and my failures with her. My vacations had been highly disruptive to Sarah; she had not been able to imagine or to ask me about this explicit demonstration of my separate existence (she never, for example, inquired or even seemed to wonder where I was going). Instead, her response to my absences had been to request regular phone contacts. I had easily agreed to these, and we spoke briefly several times weekly during many of my absences; these contacts had seemed to carry Sarah through the separation, and had not felt burdensome to me. The first clear evidence of a shift in Sarah's experience with me occurred prior to one relatively long summer vacation; she said with only slight hesitation that although she would like my phone number, she didn't think she would need to call me. She would, however, like to know where I would be. I told her, and we chatted briefly about her own familiarity with the area. Sarah said goodbye warmly and with less anxiety than usual. She did not phone or feel the need to do so that summer.

Since that time, Sarah's need for holding has progressively receded. Her capacity to "take me in" as a real object has, however, developed slowly. She periodically responds to painful experiences with a need for holding and still struggles with considerable anxiety when she feels disappointed or angry with me. Nevertheless, Sarah is now able to take the chance of letting me in on her more complicated feelings about me in a very different way. In this sense, I believe that Sarah is on the way toward collaboration and increasingly is able to tolerate my own subjectivity.

## **The Analyst's Subjectivity and Collaboration**

My own reactions with patients during the transition toward collaboration have been complex. Despite the strain inherent in the containing



position, I can feel gratified by my importance in my patient's life, by the clear indications that the patient is being helped by the treatment. My position as a “good object” is preserved in the patient's and my own eyes, and to a degree this can offset the difficulty inherent in the work. It is easier, in some ways, to stay “out,” to protect both the patient and myself from my idiosyncratic and sometimes unreliable personhood.

The transition toward collaboration disrupts this “good analyst” position. When issues related to object usage predominate, I find myself to be the focus of my patient's sometimes very insistent probing (Ghent, 1992). During this period I must tolerate alternately being experienced as a real, external object, and as a subjective one. As an external object, I am perceived from the outside as real, selfish, very human, and thus no longer especially reliable. There is gain and loss involved here. Certainly, a patient's ongoing scrutiny of me and attacks on me can leave me feeling quite vulnerable and exposed. Yet, at the same time, this insistent probing of me and my aliveness is deeply satisfying. It is also enormously relieving to be in a position to reveal my own *uncertainty*, to let my patient know something about my variability, vulnerability, and my internal struggles in the treatment. In fact, an emphasis on the analyst's survival of the patient's destructive attacks actually obscures the real pleasure that can be derived from being “made use of” by the patient. This pleasure, perhaps like the mother's experience of her children's greedy use of her, may serve to enhance the analyst's sense of her own vitality, aliveness, and internal richness.

Paradoxically, then, it is the loss of the illusion of attunement implicit in the experience of object relating that ultimately will allow for a more truly mutual and alive relationship between patient and analyst. As the patient's capacity for collaboration develops, I find that both my patient and myself are increasingly free—to move, breathe, and *be* within the psychoanalytic context. The transitional space that was quite narrow and constraining during the holding period widens in a way that will permit both of us more emotional leeway, and ultimately a fuller integration of the mutual yet asymmetrical (Burke, 1992) aspects of our relationship.

To conclude, I would argue for a reconsideration of the holding function as one dimension of relational psychoanalytic work. I suggest that the holding process contains an implicit and essential illusion. The holding experience describes a period during which the analyst temporarily

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brackets, but does not abandon, her subjectivity. It is critical primarily in work with patients who cannot easily or usefully tolerate “knowing” the analyst. I further believe that only when these intense holding periods gradually give way to the patient's reactions to the analyst as external object does the patient become fully able to expose, address, and integrate profoundly private self-experiences. This progression is anything but smooth and will involve both tacit negotiation and struggle within and between patient and analyst. The ultimate goal of such a process is the development of a capacity to be with both the self *and* with the analyst in a truly intersubjective way.

## References

- Aron, L. (1991), The patient's experience of the analyst's subjectivity. *Psychoanal. Dial.*, 1: 29-51. [→]
- Aron, L. (1992), Interpretation as expression of the analyst's subjectivity. *Psychoanal. Dial.*, 2: 475-508. [→]
- Balint, M. (1968), *The Basic Fault*. London: Tavistock. [→]
- Bion, W. (1962), *Learning From Experience*. London: Heinemann. [→]
- Bollas, C. (1987), *The Shadow of the Object*. New York: Columbia University Press.
- Bromberg, P. M. (1991), On knowing one's patient inside out: The aesthetics of unconscious communication. *Psychoanal. Dial.*, 1: 399-422. [→]
- Burke, W. F. (1992), Countertransference disclosure and the asymmetry/mutuality dilemma. *Psychoanal. Dial.*, 2: 241-271. [→]
- Casement, P. (1991), *Learning From the Patient*. New York: Guilford.
- Epstein, L. (1979), The therapeutic function of hate in the countertransference. In: *Countertransference*, ed. L. Epstein & A. Feiner. New York: Aronson, pp. 213-234.
- Epstein, L. (1987), The problem of the bad-analyst-feeling. *Modern Psychoanal.*, 12: 35-45. [→]
- Fosshage, J. L. (1992), The self and its vicissitudes within a relational matrix. In: *Relational Perspectives in Psychoanalysis*, ed. N. Skolnick & S. Warshaw. Hillsdale, NJ: The Analytic Press, pp. 21-42.
- Ghent, E. (1992), Paradox and process. *Psychoanal. Dial.*, 2: 135-159. [→]
- Ghent, E. (1993), Wish, need, and neediness: Commentary on Shabad's “Resentment, indignation, entitlement.” *Psychoanal.*

*Dial.*, 3: 495-508. [→]

Hoffman, I. Z. (1991), Discussion: Toward a social-constructivist view of the psychoanalytic situation. *Psychoanal. Dial.*, 1: 74-105. [→]

Hoffman, I. Z. (1992), Some practical implications of a social-constructivist view of the psychoanalytic situation. *Psychoanal. Dial.*, 2: 287-304. [→]

Jacobs, T. J. (1991), *The Use of the Self*. Madison, CT: International Universities Press.

Khan, M. (1963), The concept of cumulative trauma. In: *The Privacy of the Self*. New York: International Universities Press, 1974, pp. 42-58.

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Kraemer, S. (in press), "Between the dark and the daylight" of maternal subjectivity: Meditations at the threshold.

*Psychoanal. Dial.* [→]

Little, M. (1951), Countertransference and the patient's response to it. *Int. J. Psycho-Anal.*, 32: 32-40. [→]

Mahler, M. (1968), On human symbiosis and the vicissitudes of individuation. *J. Amer. Psychoanal. Assn.*, 15: 740-763. [→]

Mitchell, S. (1988), *Relational Concepts in Psychoanalysis*. Cambridge, MA: Harvard University Press.

Mitchell, S. (1991a), Contemporary perspectives on self: Toward an integration. *Psychoanal. Dial.*, 1: 121-148. [→]

Mitcher, S. (1991b), Wishes, needs and interpersonal negotiations. *Psychoanal. Inq.*, 2: 147-170. [→]

Mitchell, S. (1993), *Hope and Dread in Psychoanalysis*. New York: Basic Books.

Modell, A. (1975), A narcissistic defense against affects and the illusion of self sufficiency. *Int. J. Psycho-Anal.*, 56: 275-282.

[→]

Modell, A. (1976), The holding environment and the therapeutic action of psychoanalysis. *J. Amer. Psychoanal. Assn.*, 24: 285-307. [→]

Newman, K. (1984), The capacity to use the object. In: *Psychoanalysis: The Vital Issues*, ed. G. H. Pollock & J. E. Gedo. New York: International Universities Press, pp. 149-175.

Ogden, T. H. (1992), The dialectically constituted/decentred subject of psychoanalysis. II. The contributions of Klein and Winnicott. *Int. J. Psycho-Anal.*, 73: 613-626. [→]

Ogden, T. H. (1994), *Subjects of Analysis*. Northvale, NJ: Aronson.

Pizer, S. (1992), The negotiation of paradox in the analytic process. *Psychoanal. Dial.*, 2: 215-241. [→]

Sandler, J. (1960), The background of safety. *Int. J. Psycho-Anal.*, 41: 352-356. [→]

Shabad, P. (1993), Resentment, indignation, entitlement: The transformation of unconscious wish to need. *Psychoanal. Dial.*, 3: 481-494. [→]

Slochower, J. (1991), Variations in the analytic holding environment. *Int. J. Psycho-Anal.*, 72: 709-718. [→]

Slochower, J. (1992), A hateful borderline patient and the holding environment. *Contemp. Psychoanal.*, 28: 72-88. [→]

Slochower, J. (1993), Mourning and the holding function of shiva. *Contemp. Psychoanal.*, 29: 352-367. [→]

Slochower, J. (1994), The evolution of object usage and the holding environment. *Contemp. Psychoanal.*, 30: 135-151. [→]

Slochower, J. (1996), Holding and the evolving maternal metaphor. *Psychoanal. Rev.*, 83: 195-217. [→]

Slochower, J. (in press b), *Holding and Psychoanalysis: A Relational Perspective*. Hillsdale, NJ: The Analytic Press.

Spitz, R. (1956), Countertransference. *J. Amer. Psychoanal. Assn.*, 4: 256-265. [→]

Stern, D. (1992), Commentary on constructivism in clinical psychoanalysis. *Psychoanal. Dial.*, 3: 331-364. [→]

Tansey, M. J. (1992), Psychoanalytic expertise. *Psychoanal. Dial.*, 2: 305-316. [→]

Winnicott, D. W. (1947), Hate in the countertransference. In: *Through Pediatrics to Psychoanalysis*. London: Hogarth Press, pp. 194-203.

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Winnicott, D. W. (1960a), The theory of the parent-infant relationship. In: *The Maturation Processes and the Facilitating Environment*. New York: International Universities Press, 1965, pp. 37-55. [→]

Winnicott, D. W. (1960b), Ego distortions in terms of true and false self. In: *The Maturation Processes and the Facilitating Environment*. New York: International Universities Press, 1965, pp. 140-152. [→]

Winnicott, D. W. (1963a), Psychiatric disorder in terms of infantile maturational processes. In: *The Maturation Processes and the Facilitating Environment*. New York: International Universities Press, pp. 230-241. [→]

- Winnicott, D. W. (1963b), Dependence in infant-care, in child-care, and in the psycho-analytic setting. In: *The Maturational Processes and the Facilitating Environment*. New York: International Universities Press, pp. 249-259. [→]
- Winnicott, D. W. (1964), The importance of the setting in meeting regression in psycho-analysis. In: *Psychoanalytic Explorations*. Cambridge, MA: Harvard University Press, pp. 96-102.
- Winnicott, D. W. (1965a), The development of the capacity for concern. In: *The Maturational Processes and the Facilitating Environment*. New York: International Universities Press, pp. 73-82. [→]
- Winnicott, D. W. (1965b), The mentally ill in your caseload. In: *The Maturational Processes and the Facilitating Environment*. New York: International Universities Press, pp. 217-229. [→]
- Winnicott, D. W. (1969), The use of an object and relating through identifications. In: *Playing and Reality*. New York: Basic Books, 1971, pp. 86-94. [→]

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