typical exchange occurred after Karen described an ongoing obsession of hers concerning whether to send her ex-boyfriend a Christmas card.

Karen: I don’t know what he’d do if he got a card from me.
J.S.: I guess the hope is that he’d accept it and call you and the worry is that he won’t.
Karen: I guess [long silence]. Anyway, it’s all a game.
J.S.: What’s the game?
Karen: If you don’t know by now what’s the point of talking?
J.S.: You really want me to know exactly what you mean by a game.
Karen: I suppose. But then shrinks only tell you what they feel like telling you.
J.S.: Why would I want to withhold information from you?
Karen: Who knows. God knows you’d never tell [long silence].
J.S.: [feeling on solid ground conceptually and ignoring a growing sense of futility about communicating my understanding to Karen]: Is it possible that sending the card would be a bit like trying to get him to finally act like you can’t get your father to?
Karen: Obviously. So what? How much mileage can you get out of that one? And what difference does it make anyway? This is a waste of time.

Actually, from my point of view, the material was quite new, and far from integrated. However, in pursuing this line of inquiry, I had unconsciously attempted to override my developing sense that Karen absolutely was not interested in deepening her understanding of her own process. By offering my understanding, I appeared to be doing my job and I was able to relieve a growing sense of helplessness about the state of our work; I did not, however, seem to help Karen in any discernable way.

Over the next few months, my sense of helplessness increasingly transformed into one of alarm. Karen remained indifferent to her plight. She continued to provoke new conflicts with friends and relatives with no apparent memory of their painful effects. She acted unconcerned about the deterioration of several important relationships. She quit her job, staying at home for long periods. She showed no curiosity or concern about herself and continued to ignore or belittle all my interventions. Yet her response did not seem simply to reflect depression; there was an unmistakable undertone of active dismissal in her tone and manner. When I identified this and inquired about it, she responded with apparent disinterest, saying only “that could be.”

Toward the end of the first year of treatment, Karen gradually became more engaged with me. This engagement was first evident in her request that I describe my theory of therapy to her, so that she could compare it to that of her friend’s therapist. I responded internally with a sinking feeling that there would be no good outcome to this one, that nothing I could say would be satisfactory or helpful to her. I again tried to override that feeling, however, and asked Karen what in particular about my way of working concerned her. She reacted to this slight with rage, and attacked me for wanting to understand rather than simply to respond.

The next few weeks were solely taken up with this issue. Karen persisted in attacking my idea that her request needed to be understood. She dismissed with scorn my efforts to explain why I felt that understanding should precede action. She mocked my attempts to communicate that I understood how frustrated she felt at my unwillingness to simply answer. Her rage at me escalated. She refused to cooperate in investigating her ideas about her therapy or her friend’s, or about anything else. She attacked me with increasing vigor for my withholding stance. She accused me of being a fraud, of exploiting her financially, and of hiding my knowledge about her in order to have power over her. After weeks of unremitting sessions like these, I felt that a stalemate had been reached. Again, overriding my sense of the futility of a response, I decided directly to address Karen’s question about how I viewed the treatment process.

Karen: Apparently you don’t know how treatment works since you won’t answer my question.
J.S.: I guess that’s one possibility. Actually, I’m not sure what purpose answering would serve. But I guess I’ll accept your conviction that you need to know and give it a try.
J.S.: Well you know that I prefer to understand before acting. My idea is that if we could get to better understand what Sam means to you and how he evokes old feelings in your life now, that you might get to feel less like your life stopped when you broke up. Talking about your ideas and feelings in the present and the past gives us a way of helping make some of those connections. I see that as a first step in getting rid of the awful feelings you keep complaining of.
Karen: My, what sophistication, what insight. Are you taking as long as possible to do this?
J.S.: Why would I want to do that?
Karen: Obviously, to get as much money from me as possible.
J.S.: So my goal as a therapist is to rip you off.
Karen: You got it. And if you knew all this before, why not say it before, except to string me along.
J.S.: So I’m not only incompetent, I’m manipulative.
Karen: [mockingly] So I’m not only incompetent, I’m manipulative.

Karen’s scornful response to my attempt to answer her question was followed by further rageful attacks on me. She continued to express her fury with me, now both for having held out so long and for
the stupidity of my ideas. Her hateful and contumacious feelings dominated the sessions. She scrutinized and sarcastically attacked my every action or inaction, so that my behavior and not hers became the sole focus of the treatment. For example, she used a watch with a second hand to time our sessions, elaborately consulting it as she lay down on the couch and again as she sat up at the end. At the end of the month I received a check from which two dollars had been deducted for a minute that she had been "cheated out of." It is noteworthy that I was not altogether certain that I had not, in fact, cheated her out of a minute, given my wish to end our sessions as early as possible.

Karen was consistently unwilling to consider the meaning of our interaction, or its possible relationship to other interpersonal conflicts. We were at war and retaliation was her only possible response. Each session continued to address one or another of my failures. She never attempted to understand the source of her rage at me with sarcasm. Even when I felt fairly certain that she had felt understood by a statement I made, she bitterly complained that I was reiterating old ground and was wasting her time for mercenary ends. My silence was met with sarcastic comments about my laziness. When I inquired about her silence, she would mockingly repeat my inquiry and then lapse into further silence.

My experience with Karen gradually shifted away from any sense of genuine interest or empathy with her emotional plight. I began to despair of the possibility of communicating my understanding of her rage and underlying unhappiness and their sources. Increasingly, I dreaded our sessions and questioned the efficacy of my work with her. I was both furious and puzzled by the relentlessness of her sarcasm. I entertained fantasies of retaliating. (I imagined bashing her head with a pencil. I continued to hold the pencil in the vain hope that by taking notes I would divine some useful meaning from the material that was eluding me.) I entered our sessions girded for an onslaught, hoping more to survive her attack than actually to be of use to her.

It was only when the intensity of my own fury and helplessness had escalated, however, that I was able to move in the direction of a holding stance with Karen. That stance helped me find a way simultaneously to tolerate and contain Karen’s ongoing aggressive attacks while refraining from an active use of interpretation or even empathic statements as a way of coping with the strain of such attacks in an apparently hopeless treatment situation. However, such silent containment alone carried with it the risk that Karen would feel that she had injured or destroyed me. Thus, it was essential that I find a way to make use of my feelings through contained yet affectively toned communications. Those communications would, I hoped, confirm my aliveness and my capacity to bear attack without injury, and in this sense would represent an implicit interpretation to Karen about the limits of her destructiveness.

To the extent that Karen’s underlying unconscious conviction was that she could not, in fact, make an impact on me (or any object), my neutrality would tend to confirm that fear. In contrast, by meeting her rage with a very modulated aggressive stance, I might provide evidence that she did affect me but would not destroy me. To that end, I began to limit my interventions to concrete questions, responding to Karen only when she engaged me directly, and meeting her attacks with dry or mildly annoyed responses.

Karen: [enters, silent]
J.S.: [after 3 minutes] So, what’s on your mind today?
Karen: [mockingly] So, what’s on your mind today?
J.S.: [dryly] Annoyed, are you?
Karen: Why should today be different? You never have anything to say that’s new.
J.S.: Brilliant new ideas about what?
Karen: Well, last time you made another stupid comment about my father. You could have said that a year ago.
J.S.: Stringing you along again, huh?
Karen: Yeah, waiting to raise my fee.
J.S.: By the way, is it true, about your father?
Karen: You think I’d tell you if it were?
J.S.: Question withdrawn.

At other moments, Karen’s attacks lacked even this slightly playful quality.

Karen: [enters, glowering with fury, silent for 10 minutes despite several queries from me] You think you know everything.
J.S.: What do I know?
Karen: Why the hell should I tell you? You are a pathetic example of an analyst.
J.S.: [dryly] Well, this pathetic analyst would like to know what the hell I said that bothered you.
Karen: And give you more ammunition? In my next life [long silence].
J.S.: So should I try to get you to talk or not?
Karen: [mimicking] So should I try to get you to talk or not?

Karen left these sessions in a fury, slamming the door behind her. Although she did appear to feel less depressed when she entered, the therapeutic efficacy of my interventions was rarely immediately clear to me. Nevertheless, Karen’s overall response to this shift in stance was striking. She persisted in attacking me and my theories of
treatment and she countered my every remark; however, her silent stance was replaced by a caustic but lively one. Her engagement with me became far more active; silent periods decreased in frequency and length. Karen obviously enjoyed her considerable cleverness in challenging my statements during the exchanges that she termed our “fights.” When I retreated into silence out of fatigue or real anger, she became increasingly vicious and arrived at subsequent sessions depressed, perhaps unconsciously convinced that I had been injured by her, and fearing retaliation.

My emotional response to Karen during this period shifted only slightly. I felt somewhat more alive during our exchanges, and occasionally I even enjoyed the rapid banter that characterized them. However, I continued to doubt the therapeutic value of a treatment based in such acrimony. I responded to Karen’s persistent nastiness with a feeling of defeat, and finally asked her whether I should consider referring her elsewhere for a consultation. Karen sarcastically refused, and then offered, in a most offhand way, the first evidence I had of improvement in her external life. She had made up with a friend, and had in fact made the first conciliatory overture. She had also obtained a new and possibly better job. This was all said in passing. She would not speculate about the source of these changes and quickly returned to her attacks on me. Her response nevertheless suggested to me that Karen had perhaps been helped by our work, and that her dependence on the treatment, though rarely visible, was real, and had been aroused by my indication that I was prepared to give up.

Karen continued to focus the sessions on me and my failures throughout the next year. However, she made an increasing number of oblique references to her outside life that indicated a marked decrease in the intensity of conflict in her important relationships. During the third year of treatment, the relentlessness of these attacks slowly diminished, and Karen occasionally told me about the people in her early and current life. She began to consider the notion that other people experience conflict and act on the basis of their feelings, and she speculated about how conflict operated within her family. My sense of dread prior to her sessions diminished, and I began to feel slightly freer to function with her on the basis of my understanding.

Throughout this period, however, Karen rarely addressed her own experience or feelings directly; instead she remained safely on the emotional exterior of her speculations, only toying with the idea of self-examination. Any attempt on my part to investigate her experience of her parents’ behavior brought on a renewed phase of sarcasm and silence. Karen was now sufficiently secure within the analytic frame to introduce her world of real objects, but not to address her internal experience of them. This nevertheless represented a significant step in the direction of a capacity for self-reflection.

During the subsequent years of our work together, Karen slowly developed some tolerance for contact with me. Her outbursts of rage subsided, and were replaced by expressions of annoyance that were more appropriate and directly reactive to my failures in understanding.

It seems, then, that the holding process served a therapeutic function by creating a sufficiently contained space within which Karen could fully elaborate on her most painful affective states. When I held these states, Karen was able to discover her own resilience as well as mine, and that discovery ultimately altered her self-experience in a way that permitted some movement beyond issues of hate toward self-examination.

Of course, it is not always possible for the analyst to provide the patient with implicit reassurance that the analyst is surviving the patient’s attacks. This can be difficult when the analyst herself is not so sure that she is surviving, or when the patient cannot easily integrate the reality of the analyst’s intactness. Active attention to these issues will be crucial to the therapeutic effect of a holding process.

Countertransference Resistances to Holding

It is difficult for the analyst to retain a position of conviction about the therapeutic efficacy of a holding response to a patient’s ruthlessness, and close to impossible with a hateful patient. Such attacks inevitably touch off our anxiety, vulnerability, self-doubt, and defensiveness, sometimes to such an extent that we may give up, and choose literally or indirectly to terminate the treatment, often quite unilaterally. Even if we refrain from so drastic a move, in such situations it can be most tempting to break into the patient’s distress or rages with interpretations that actually function as disguised attacks (Epstein, 1979, 1987). The purpose of these attacks is to rid the analyst of the intense anger and/or helplessness that tend to be evoked when one is subjected to a relentlessly tense analytic situation. It is only with ongoing internal work that the analyst can maintain a holding stance here.

An experienced analyst once told me that she felt utterly “derailed.” Ms. A. had subjected him for months to a barrage of complaints about, criticisms of, and muted and overt attacks on his analytic acumen. His attempt to interpret the source of her rage and dissatisfaction had only intensified the patient’s unhappiness. The analyst felt prepared to admit defeat, to refer Ms. A. elsewhere in the hope that another analyst (perhaps, he thought, a
woman) would find the right touch with Ms. A. The only hesitation he felt about making this move came from Ms. A.'s apparent disinterest in looking elsewhere for help; in fact, when he suggested such a referral, she became quite upset with him and indicated that she did not want to end the analysis. He was, he felt, up against a wall; his choices were to unilaterally terminate the analysis or to continue to work with her in a seemingly hopeless treatment context.

What the analyst had not considered, I felt, was the possibility that the therapeutic task with Ms. A. involved precisely that dimension of their relationship that he found unbearable; that Ms. A. needed him to tolerate massive feelings of hopelessness, helplessness, and rage—without retaliation or interpretation. The purpose of this holding stance would be to help Ms. A. experience the safety of the analytic setting and of the analyst as she elaborated on these painful affective states. Because of the power of her own self-hatred, it was only within the context of the analyst’s absolutely even, nonretaliatory survival that Ms. A. could test out and discover the limits of her destructiveness. Yet for the analyst to continue working with her, he would have to be prepared to hold onto that knowledge in an emotional situation that absolutely negated it. That is, the work with Ms. A. would be unlikely to shift rapidly in a more positive direction, and his engagement with her meant that he would inevitably feel more frustrated, angry, and hopeless than otherwise.

In this sense, holding work here required that the analyst find a way to sustain himself without retaliating against the patient through the use of apparently neutral interpretations that effectively place the “badness” back into the patient (Epstein, 1979). Even then, it was likely that the analyst would feel intensely uncertain that the patient was experiencing sustained internal change, and he would instead continue to struggle periodically with overwhelming doubts about the therapeutic efficacy of the work.

Holding Ruthlessness or Hate and the Analyst’s Attunement

What is the therapeutic function of holding with ruthless or rageful patients? The analyst’s reliable containing function provides the desperate patient with a set of powerful reassurances that ultimately may result in heretofore absent therapeutic action. These reassurances concern two pivotal issues. First, the patient receives evidence of the analyst’s capacity both to tolerate and to survive the patient’s emotional impact. That evidence is provided by the even steadiness of the analyst’s boundaries. The analyst survives intact, and, by not retaliating (literally or via interpretation), reassures the patient that she is not capable of destroying the analysis or the analyst.

At the same time, however, the holding stance provides the patient with the experience of making an emotional impact on the analyst. Because the analyst makes use of her emotional responses to the patient in her affective tone, the patient derives steady evidence that she is, in fact, impacting on the analyst. For many patients, this may be the first such experience—the first evidence that their affective communications are neither warded off nor retaliated against. It is the patient’s simultaneous experience of having feelings of ruthlessness or hate received and tolerated that is pivotal to a therapeutic effect in these treatment situations.

Because the analyst uses her subjectivity to some degree, the holding function here is somewhat more inclusive of the analyst’s affective experience than with patients needing holding around dependence or self-involvement. The analyst does not fully bracket her subjectivity, but instead allows it partial expression through the emotional tone of her interventions. The analyst and patient consequently may feel less of a need to fully set aside aspects of their knowledge of the other during the holding process.

Dangers Inherent in Holding Ruthlessness and Hate

The risks involved in the suspension of interaction around the patient’s affective impact are similar to those which characterize holding issues of self-involvement. The analyst may resort to what appears to be a holding stance in retaliation for the patient’s overt or covert sadism. This retaliation will become quite evident because it is likely to result in a rapid escalation of the patient’s distress and/or her attacks on the analyst.

Alternatively, it is possible that the analyst’s abandonment of explicit interpretive work will be experienced by the patient as a withdrawal and/or an expression of the analyst’s impotence. This is especially likely when the analyst is feeling undermined and resorts to a holding stance in order to protect herself.

An analyst reported that she had moved toward a holding stance with an especially difficult, provocative patient. The patient, however, responded with an escalation of her attacks on the analyst. As we began to examine the nature of the analyst’s subjective experience of the patient, it became clear that the analyst’s voice conveyed a measure of what she was feeling, mainly, a sense of hopelessness about being of help to the patient. That affective tone belied the analyst’s tough words, and made the patient intensely anxious. The patient’s
attacks reflected her unconscious attempt to test the analyst’s potential for both aliveness and destructiveness.

**Effects of Disruptions During Holding**

Although disruptions of the holding function will always impact on work with ruthless or hateful patients, that disruptive effect is likely to be less devastating than it can be with dependent or self-involved patients. When the patient’s capacity to express rage is accessible, there is a possibility that the patient will be able to articulate her reaction to the analyst’s failure. However, to the degree that the disruption of the holding function exposes the patient’s hidden dependence on the analyst, the patient is likely to respond intensely, often by abruptly truncating the treatment or threatening to do so.

Steve, a patient with whom I had worked for some years, presented a nearly monochromatic picture of bitterness and hopelessness, within which I rarely if ever “came up to snuff.” I struggled with anger at his treatment of me, but tried to maintain a relatively even, somewhat tough stance vis-à-vis his contempt.

During a particular session, Steve presented a difficult work situation to me in what felt like a straightforward (i.e., nonprovocative) way. I spontaneously responded without thought, saying “God, that’s awful,” and then asking him whether he had considered the possibility of responding to his boss by taking account of the envy that appeared to lie behind his boss’s attacks. (I was not conscious at that moment of the implicit connection to Steve’s own behavior.) Steve seemed to appreciate my suggestion, and left with an easy, almost friendly goodbye. However, he returned the next day in a quiet fury. I had, in his words, “acted out,” and become controlling. He did not connect his fury to the content of my intervention, but rather to the fact that I had commented in a practical way about his outside life. This meant that he could not trust me. He wondered whether he should leave the analysis, and whether I had any boundaries at all.

Steve’s rageful reaction to my intervention seemed to emanate from several sources. My suggestion was probably assimilated in terms of Steve’s own (disavowed) envy of and dependence on me and my potential “helpfulness.” I had penetrated Steve’s rigidly autonomous stance and thereby evoked a complex of feelings of destructive envy and energetically denied dependency wishes with such intensity that Steve could restore his sense of emotional intactness only by attacking me.

It was with some difficulty that I engaged him again within a holding frame that was sufficiently bounded to restabilize the treatment.

That frame involved two key elements. First, I maintained the treatment boundaries in an especially clear way; I virtually never commented or otherwise responded to him with spontaneous reactions, suggestions, or the sort of relaxed comments that sometimes mark the beginning or ending of sessions. Second, I attempted to increase Steve’s feeling of safety by dealing with his contempt with a firm but noninterpretive response. Interpretations aroused his envy and rage, and silence confirmed for him that I had been injured by his attack.

I do not mean to imply that from this point forward, the treatment evolved in an easy or a straightforward way. On the contrary, I continued to struggle with Steve, with his anger and contempt, his bitterness and periodic hopelessness. However, within the solid reassurance of a holding context Steve began to tolerate the always implicit dependency intrinsic to analytic inquiry and the analytic relationship.

**The Self-Holding Function**

How does the analyst need to hold herself with ruthless or hateful patients? Here, perhaps more than in any other treatment context, the analyst holds herself by holding onto the complexity of her feelings toward the patient, and most especially her own rage. It is primarily when that rage becomes dissociated (often because it does not fit the analyst’s self-image as a knowing, even presence) that the holding process is likely to break down.

**Holding in Ordinary Treatment**

How are ruthlessness and hate held in ordinary treatment contexts? Often quite easily. It is only when such emotional factors take over the treatment that the analyst is subjected to intense strain. Nevertheless, the analyst’s capacity to accept and live with such feelings without retaliating against the patient can be crucial in any treatment context. It becomes difficult for us to do this primarily when we feel implicated, to some degree, in the patient’s accusations.

Bill has been in twice weekly therapy with me for 3 years. Following a session during which he received his bill, he returned with his bill in hand, looking quite angry. He noted that I had misspelled his name, and expressed disgust at my not knowing who he was. He was somewhat uncharacteristically furious, and blasted me for the duration of the hour. I struggled with my wish to explain myself, to get myself off the hook. I wanted to tell him that I periodically do make such errors in writing names, that he should not take the error personally. I also felt the wish to work interpretively with both his response and my
own, with his quick assumption of being forgettable, and with his ideas about why I made the error. (I was also aware that I needed to examine more closely just why I had made this error with Bill.) It was with difficulty that I accepted Bill’s anger and neither explained myself nor worked interpretively with his upset.

Why, then, did I not further explore with Bill the meanings of my error? Certainly, Bill would have been able to accept and work with an interpretation around his assumption of his being forgettable. However, that work was ongoing anyway. In making use of my failure to interpret Bill’s affective response, or by speculating with him about my process, I would have short-circuited an opportunity for Bill to express, untempered, his anger and clear view of my real failure. In that sense, I would have inadvertently redirected the “pathology” toward Bill, gotten myself off the hook, and, most importantly, deprived Bill of the experience of safety and fully expressing rage toward an object who could both receive and survive it.

Chapter 6
On the Edge: Working Around the Holding Process

In the preceding three chapters, I have tried to delineate the core emotional situations that may require a holding process in psychoanalytic work. None of these experiences is likely to be easy. When, however, patient and analyst find their way into a holding process and can tolerate its uncertainty, that experience may alter the progression of analytic work in a dramatically different and more positive direction.

In this sense, all varieties of holding processes carry with them a hope—that the analyst’s very capacity to tolerate her subjective experience without explicit expression ultimately will facilitate increasingly complex emotional processes within the patient, a deepened level of self-understanding, and also a new possibility for mutual dialogue.

Yet there are moments with some patients, and protracted periods with others (or with some analyst–patient pairs), when interpretive work fails and a holding experience also does not result in a gradual build-up of confidence in the analyst’s affective attunement, or in the patient’s internal resources. There are patients who seem to remain on the perimeter of the treatment experience, forever returning to states of mistrust and despair about themselves as well as the analytic process.

Although these individuals may hope for the analyst’s attunement, and thus toy with the possibility of intimacy and deeper self-exposure, they simultaneously are extraordinarily skittish in a way that makes a holding experience elusive. Here, the analyst’s reliability is never satisfactorily assessed, so that a relaxation of strain on the patient’s part inevitably is followed by its intensification. Most paradoxically, what is desperately needed is precisely what the analyst so often fails to provide from the patient’s point of view. Unlike the rageful reactions described in Chapter 5, the primary response to analytic process here involves a cycle of hope and despair.

To the degree that it is the object’s capacity for attunement that is most untrustworthy, the analytic situation may evoke not only hope but also fear of a particularly poignant sort. If only the analyst could be trusted, the patient could relax in a situation where real self-exposure