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"The Holding Environment" and the Therapeutic Action of Psychoanalysis

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AT THE CONGRESS IN MARIENBAD in 1936, Glover (1937) observed that "it is essential that our theory of therapeutic results should keep pace with the complexity of ego development and with the complexity of our etiological formulae" (p. 127). This paper is an attempt to respond to Glover's succinct advice, for, as we enlarge the scope of psychoanalysis to include an ever-increasing range of people who are said to suffer from disorders of ego development, we are forced to consider for these people a theory of the therapeutic action of psychoanalysis different from that we use with the so-called "classical case."

The isolation of those factors which underlie therapeutic change in psychoanalysis is not a secure area of knowledge; it is easier to identify the forces that interfere with the progress of an analysis than to understand what contributes to its therapeutic success. Our theory of therapeutic change in psychoanalysis may itself be constantly changing due to the changing nature of the neuroses. This theory is obviously linked to the subject of transference where a final understanding also seems continually to elude us. A thorough examination of the theory of therapeutic action of psychoanalysis is beyond the scope of this paper: it should be understood that the following account is necessarily cursory and simplified.

I believe that most analysts would accept James Strachey's

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description (1934) that structural growth is effected by means of sparingly employed mutative interpretations. Interpretations are only effective when certain conditions are met: in Strachey's words, "every mutative interpretation must be emotionally 'immediate'; the patient must experience it as something

actual" (p. 286). He says further that the interpretation must be directed to the "point of urgency." This means that very precise conditions must be present regarding the state of the patient's affects. It must be assumed that the patient is in a state of affective relatedness so that the "point of urgency" can be perceived by means of the psychoanalyst's empathy—that is to say, there must be an affective bond. It must further be assumed that the patient's affective experience is of a certain intensity—that is, intense enough to experience the immediacy of feeling but not so intense as to overwhelm him. We know that Strachey believed that the transference interpretations are likely to have the greatest "urgency" and that mutative changes are most likely to occur through the interpretation of a transference. Differences of opinion exist regarding this point: there are those who would place transference interpretation at the very center of the therapeutic process, while others, such as Anna Freud (1969), would give equal weight to interpretive reconstruction utilizing memory, free association, and dreams. Further controversy exists over the effectiveness of interpretation in the presence or absence of a therapeutic alliance: a majority opinion would believe that transference interpretations are mutative, that is, that they produce structural change only when self/object differentiation has been achieved so that the patient can accept the analyst as a separate person and can collaborate actively (Zetzel, 1956). Kleinian analysts would take a minority view, believing that transference interpretations can be effective even in the absence of a therapeutic alliance. (For a discussion of this controversy see Greenson, 1974); (Rosenfeld, 1974.)

But if we leave these controversies aside, all analysts are

united in the view that interpretations can be effective only when there is, in Strachey's terms, a "point of urgency," that is to say, affect that is genuine and communicated.

It is further believed that mutative interpretations lead to structural change by means of a series of innumerable small steps. This results in a growing identification of the patient with the analyst's "analytic attitude" (Bibring, 1937). Strachey emphasized the modification of the patient's superego, but we would now include the modification of the ego and the sense of self.

The theory that the therapeutic action of psychoanalysis requires a certain state of affective relatedness would have to be modified as it applies to the psychoanalysis of narcissistic character disorders. For in the opening phase of the psychoanalytic treatment (a phase which may last for a year or more) there is a persistent state of affective nonrelatedness.

We can confirm Kohut's (1971) description of a syndrome defined operationally by the development of a transference consisting of externalizations of part of the self or the undifferentiated self-object, which he called the mirror transference, and the idealizing transference. The uniformity of this particular transference manifestation, in contrast to the transference neurosis, whose content is unique, is of special interest and will be discussed later in this paper. We agree with Kohut that this group is essentially neurotic and not psychotic and can be distinguished from borderline patients (see also Kernberg, 1974); (Modell, 1975b). The diagnosis of this syndrome is also aided by a particular form of the countertransference response (Modell, 1973), which is the result of the patient's state of nonrelatedness. The analyst reacts with a sense of boredom and sleepiness to this massive affect block and to the realization that he is continuously in the presence of another person who does not seem to be interested in him. Although the analyst's withdrawal may be defensive, I do not believe it is necessarily neurotic — it is a human reaction to the patient's state of nonrelatedness. The patient's speech usually has a

monotonous, dry, or empty quality, traumatic events are related with such absence of feeling that the analyst must struggle against becoming indifferent. Dreams are also shorn of affect and can only rarely be interpreted. Strachey's criterion for interpretation — the state of affective relatedness — "the point of urgency" is lacking, and, further, there is an absence of a therapeutic alliance. In the absence of both transference neurosis and a therapeutic alliance, and without a point of affective urgency that permits mutative interpretations, what then provides the motive force for the therapeutic action of psychoanalysis in these patients (Kohut, 1971)?

Kohut attributes the structural growth that occurs in these cases to a process that he calls "transmuting internalization." He describes it as follows (1971): "Preceding the withdrawal of the cathexis from the object there is a breaking up of those aspects of the object imago that are being internalized" (p. 49). And further, "there takes place ... a depersonalizing of the introjected aspects of the image of the object" (p. 50). I find Kohut's concept of the "transmuting internalization" an unsatisfactory explanation of the therapeutic action of psychoanalysis in narcissistic personality disorders. It is not that I question that "transmuting internalizations" occur, for this has long been recognized: my principal objection is his theoretical frame of reference — one that focuses nearly exclusively on changes in the self, and describes these changes in terms of a distribution of narcissistic object libido. Kohut does not make use of the psychoanalytic theory of object relations; to describe qualitative differences in

libido is reminiscent of Freud's 1914 paper, "On Narcissism," a paper that preceded structural theory. Although Kohut does employ structual concepts, narcissism is separated from the development of object relations, a view antithetical to object-relations theory. (For a similar criticism see Loewald, 1973); (Kernberg, 1974.)

Theory has a selective influence upon what we choose to observe. Kohut's theoretical position that narcissism and

object relations proceed along separate developmental lines would minimize the interplay of the human environment upon the vicissitudes of development and the sense of self. This is not a minor theoretical disagreement, but a radically different model of the mind (see my discussion in Panel, 1971). Object-relations theory describes intrapsychic processes in the context of a human environment. Such a view is consistent with contemporary biological theory in that it views the world around the organism with the organism in it. This is what, in psychoanalytic jargon, has come to be called a "two-body" theory.

It is our contention, therefore, that the syndrome of the narcissistic character disorder that Kohut has so accurately described requires a theory of object relations for its fuller understanding. There is a theory of the therapeutic action of psychoanalysis that derives from the object-relations point of view. We are referring to those analysts who view the analytic setting itself as containing some elements of the mother-child relation. This point of view includes the contributions of Winnicott (1965), Balint (1968), Spitz (1956), Loewald (1960) and Gitelson (1962), among others. It is a view that would see the analytic setting as an open system, a view in which the ego must be considered in relation to its human environment.

We have adopted Winnicott's term, "the holding environment," as an evocative description of this human environment, but it should be understood that in applying Winnicott's term we are emphasizing a theory that is not exclusively Winnicott's. Winnicott introduced the term "holding environment" as a metaphor for certain aspects of the analytic situation and the analytic process. The term derives from the maternal function of holding the infant, but, taken as a metaphor, it has a much broader application and extends beyond the infantile period — where the holding is literal and not metaphorical — to the broader caretaking functions of the parent in relation to the older child (Khan, 1963). We

suggest that the mother, or more accurately, the caretaking adults, stand between the child and the actual environment and that the child and its caretaker are an open system joined by means of the communication of affects. As Winnicott (1963) put it, "... the analyst is *holding* the patient, and this often takes the form of conveying in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced, or that is waiting to be experienced" (p. 240). The holding environment provides an illusion of safety and protection, an illusion that depends upon the bond of affective communication between the caretaker and the child. We are reminded of the war-time experience of children who remained with their mothers, contrasted with those who were separated. The study made by Freud and Burlingham (1943), demonstrated that the mothers' affective signals took precedence over the actual, the external, reality: the children remained calm when the mothers were unafraid, despite the real danger. The holding environment suggests not only protection from the dangers from without, but also protection from the dangers from within. For the holding implies a restraint, a capacity to hold the child having a temper tantrum so that his aggressive impulses do not prove destructive to either himself or the caretaker. In this regard it is not uncommon to observe at the beginning of an analysis that patients will test the analyst's capacity to survive aggressive onslaughts. The holding environment provides, in Sandler's (1960) terms, a background of safety. When there is a loss of this holding environment, which may occur for a variety of reasons, such as the illness of the parents or their emotional unavailability, the child is forced into a premature maturation and, in a sense, for a period at least, ceases to be a child, for to have a childhood requires the presence of a holding environment. A child who is forced into a premature self-sufficiency does so by means of an illusion (Modell, 1975b), an illusion for which the ego pays a price.

The Holding Environment and the Analytic Setting as an Object Relationship

Others, however, have questioned whether the analytic situation does in fact recapitulate an early mother-child relation. Anna Freud (1969) states: "There is, further, the question whether the transference really has the power to transport the patient back as far as the beginning of life. Many are convinced that this is the case. Others, myself among them, raise the point that it is one thing for the preformed objectrelated fantasies to return from repression and be redirected

from the inner to the outer world (i.e., to the person of the analyst); but that it is an entirely different, almost magical expectation, to have the patient in analysis change back into the prepsychological, undifferentiated, unstructured state, in which no division exists between body and mind or self and object" (p. 40). Leo Stone (1961) is also skeptical about whether the analytic setting can reproduce aspects of an early object relationship.

As Anna Freud indicates, it would be foolish to insist that regression in analysis goes back to structurally undifferentiated states of the first or second year of life. Nevertheless, there are actual elements in the analyst's technique that are reminiscent of an idealized maternal holding environment, and these can be enumerated: the analyst is constant and reliable; he responds to the patient's affects; he accepts the patient, and his judgment is less critical and more benign; he is there primarily for the patient's needs and not for his own; he does not retaliate; and he does at times have a better grasp of the patient's inner psychic reality than does the patient himself and therefore may clarify what is bewildering and confusing.

Strachey (1934) underlined an important paradox that is implicit in psychoanalytic technique. He stated: "It is a paradoxical fact that the best way of ensuring that his [the

patient's] ego shall be able to distinguish between phantasy and reality is to withhold reality from him as much as possible" (p. 285). This paradox is also relevant to our consideration of the "holding environment." For although there are "real" caretaking elements in the analyst's customary activity, if he does in fact assume an actual protective role (such as might be necessary in certain emergencies), this will interfere with the analytic process. We wish to reiterate, therefore, that the caretaking elements we have described are implicit in the classical analytic technique itself (in Eissler's terms, without parameters). If active measures are introduced into the analytic situation, there is the paradoxical effect of weakening the analytic holding environment. (The same point has been made by Rosenfeld, 1972), (and Gitelson, 1962.)

It should also be made clear that when we speak of "real" elements in the object relation between patient and analyst as part of the caretaking function, we are not referring to the very different issue of the patient's perception of the analyst and a "real" person (Greenson and Wexler, 1969). The word "real" is used here in a different context. Again, to refer back to Strachey's paradox, the introduction of special measures to reveal to the patient the "reality" of the analyst's personality may, in the treatment of the neuroses at least, have the

opposite effect. The use of this technique in borderline and other psychotic illnesses is a separate issue.

We have discussed the so-called "actual" elements in the object tie between the patient and the analyst. We know that the situation is further complicated by the fact that this actual object tie is penetrated by the products of fantasy. That these fantasies may be primitive and may occur in young children does not mean that the patient has in fact regressed in a structural sense to the age of one or two, as Anna Freud has questioned. The fantastic elements include the magical wish to be protected from the dangers of the world and the illusion that the person of the analyst in some way stands between these dangers and shields the patient. It is the illusion that the patient is not "really in the world." There is the wish that the analyst can make the world better for the patient, without the

patient's being required to do any work—that mere contiguity to this powerful analyst will transfer the analyst's magical powers to himself.

A patient in the termination phase dreamed that she was lying on the floor holding a life-sized doll while I was seated watching her. The patient identified the doll as the analytic process that she was in danger of losing. What is of interest here is that the analytic process itself was invested with the qualities of a transitional object, apart from the person of the analyst. Although the qualities of the holding environment are generated by the analyst's technique, they may become separated from the analyst and take on a life of their own. The analytic process is not infrequently observed in dreams as a more or less protective container, such as a house or an automobile.

The gratifications that result from the analyst's functioning as a "holding environment," we must again emphasize, are not the consequence of the analyst's special activity, that is, actively giving reassurance, love, or support, but are an intrinsic part of "classical" technique. Here, gratification appears to contradict the rule of abstinence, but the nature of the gratification is quite different from that associated with libidinal or aggressive discharge. It moves silently, it is not orgastic. I have suggested elsewhere (Modell, 1975a) that the instinctual backing of object relations is of a different order from what Freud described as the instincts of the id. While this assertion remains controversial, it is not controversial to assume that the healing forces of the "holding environment" have biological roots.

The Psychoanalytic Process in Narcissistic Character Disorders

The First Phase—The Cocoon: Transference and the "Holding Environment"

Kohut's description of the idealizing and mirror transference in the narcissistic character disorder is now widely known, and

we have accepted his description as an operational method of defining the syndrome itself. What we are to describe now are other facets of transference that can be observed if we shift the focus from the self to the broader context of object relations—that is to say, the self in an environment. The complexity of the analytic process is such that what we can offer here are only partial approximations. We have the impression that the early part of the first phase of analysis, as we shall describe it, corresponds to Kohut's description of the idealizing transference. Kohut's mirror transference in its less archaic forms occurs toward the end of the first phase and the beginning of the second or middle phase of analysis. It is also to be understood that the separation of these phases is a fluid, dynamic process; the boundaries between phases are not sharp and, due to progressive and regressive movements, their sequence may be interrupted. The situation is not unlike the changing of seasons.

The initial period usually extends for a year or a year and a half, or may persist longer. It is a period of great frustration for the psychoanalyst: the patient behaves in the main as if there are not two people in the consulting room—the patient remains essentially in a state of nonrelatedness. This state of affective nonrelatedness induces a particular countertransference response that has been widely observed (Kohut, 1971); (Modell, 1973); (Kernberg, 1974). It is one of boredom, sleepiness, and indifference. In contrast to borderline patients who make intense demands upon the analyst and consequently induce intense countertransference affects, these patients attempt to maintain an illusion of self-sufficiency. They report an intrapsychic perception of this state of self-sufficiency and feel encased in a "plastic bubble" (Modell, 1968); (Volkan, 1973) or behind a sheet of glass (Guntrip, 1968) or feel that they are a mummy in a case or, as I have described earlier (Modell, 1968), they feel encased in a cocoon.[1] I have chosen

[1] *Slap (1974) has also described this phenomenon, but has mistakenly associated it with Lewin's dream screen.*

[2] *Some patients, if they are able to, will come very early to their appointments to obtain the feeling of safety and pleasure of remaining alone in the waiting room with the knowledge that I am next door.*

[3] *Freud used the analogy of an egg in another context (1911): "A neat example of a psychical system shut off from the stimuli of the external world, and able to satisfy even its nutritional requirements autistically (to use Bleuler's term), is afforded by a bird's egg with its food supply enclosed in its shell; for it, the care provided by its mother is limited to the provision of warmth" (p. 220n).*

the cocoon metaphor because it implies a potential for life. A cocoon, unlike a mummy or a plastic bubble, contains something alive and must be attached to something else that is essential for its nourishment.[2] The illusion of self-sufficiency and disdainful aloofness that these people display defends against the very opposite—that is, yearnings that are intense and insatiable. Patients' descriptions of feeling as if they were inside a plastic bubble attest to their endopsychic perceptions of deadness. It should also be obvious that these analogies may be variations of a womb fantasy—a state where one is cut off from interaction from the environment, where one is not "really in the world"; where there is an illusion of self-sufficiency and yet a total dependence upon the caretaking functions of the maternal environment.[3]

During this phase of the analytic process, although the analyst may experience boredom and indifference, the patient may be enjoying the analytic experience. With some patients we have the impression of a child playing happily by himself content to talking to himself, but he does experience a sense that he is safe in the analytic setting.

Although the analyst in the initial period may have a feeling that nothing is happening, we believe that the analytic process is set in motion by the holding environment and the tie to the analyst himself. During this period there cannot be said to be a therapeutic alliance, for this requires a sense of separateness that has not yet been established. Instead of a therapeutic alliance, we see a magic belief reminiscent of what has been described in borderline patients as a transitional-object relationship—the object stands between them and the

dangers of the real world. It is as if the patient really believes that he is not "in the world" and that there is no need for him to obtain anything for himself—there is a denial of the need to work. Implicit here is the belief that the analyst can rescue the patient in spite of himself and that the analyst has sufficient

power to preserve the analysis in spite of the patient's efforts to sabotage it. In this idealizing phase, the analyst implicitly possesses some powerful qualities so that change may be effected merely by being in his presence. It is a sense of magic based on contiguity: merely to be in the presence of the powerful object is to share his power. What I am describing corresponds, of course, to some aspects of Kohut's idealizing transference. This positively toned transference gradually gives way, for reasons to be described, to negative transference. For a cocoon is also similar to a fortress, where nothing leaves and nothing enters. The analyst begins to observe that his comments tend to be forgotten or not even heard—nothing seems to get through. The analyst's emotional position is one of acceptance, patience, and empathy—he must be able to wait. Winnicott has observed (1969): "For instance, it is only in recent years that I have been able to sit and wait for the natural evolution of the transference arising out of the patient's growing trust in the psychoanalytic technique and setting, and to avoid breaking up the natural process by making interpretations" (p. 86). Interpretations at this stage tend to be either dismissed, not heard, or resented as an intrusion. (We will return in a later section to discuss the function of interpretation.)

The Middle Period: The Emergence of Rage and the Development of the Therapeutic Alliance

In this portion of the analysis the positively toned transference gradually changes into its opposite. We begin to enter the period that can be described as one of narcissistic rage. The time of onset of this phase may be due in part to the emotional

capacities of the analyst, that is, how long he can tolerate the patient's prolonged state of nonrelatedness. But we suspect that even with the most tolerant and accepting analyst the process would shift of its own accord, for, as the regression deepens, the insatiable demands that have been warded off by denial will become more manifest. The analyst becomes more aware of the patient's insatiable needs for admiration and total attention and, in turn, becomes more confronting. This is not simply the empathic acceptance of the patient's grandiose self that Kohut has described. Here I share the observation of Loewald (1973) who states: "To my mind a not inconsiderable share of the analytic work consists of more or less actively and consistently confronting these freed narcissistic needs of the narcissistic transferences" (p. 447) (see also Kernberg [1974] on confrontation). The confrontation of the patient's grandiosity gradually gives way to a systematic interpretation of the cocoon

fantasy itself. With this activity on the part of the analyst, the affect block and state of nonrelatedness is gradually and imperceptibly altered and gives way to genuine affects, albeit that of intense rage. We have arrived at the "point of urgency" that Strachey described as the necessary precondition for giving mutative interpretations. This rage in some patients takes on murderous proportions or may lead to a defensive indifference, a regressive movement back to the earlier cocoon fantasy. I believe, with Winnicott, (1969), that the rage itself supports the process of individuation. In contrast to the rage that accompanies the Oedipus complex, the wish to destroy the parent of the opposite sex, this rage is not aimed at the analyst as a parental imago. It is less definite and more diffuse. For example, as the analyst is equated with the environment itself, he becomes the target of rage directed against external reality. This rage may also be fueled by envy—the envy itself is again diffuse and nonspecific: the patient may envy the analyst for what he is and for what he has, that is, his knowledge. As one moves through this stormy period in the analysis, a period that may

occupy months or perhaps a year or longer, one observes that the cocoon transference has been gradually dissolving—the patient no longer believes in his self-sufficiency, he is able to acknowledge his demands more directly, his extreme dependency is no longer denied. With this, comes the beginning of individuation, a sense of separateness, and the development of the therapeutic alliance. Although this may be a difficult and painful period, there is a sense that two people are present. The patient gradually, although reluctantly, begins to accept the fact that he has a responsibility for the work in the analysis.

We believe that the holding environment of the first phase has led to sufficient ego consolidation to permit a shift in the focus of therapeutic action of psychoanalysis in the second phase. And we believe that the motive force for the therapeutic action of psychoanalysis in the second phase is interpretation. Interpretation effects the dissolution of the cocoon transference in a manner analogous to the use of interpretation to effect the dissolution of a transference neurosis. It should be understood that, in contrast to the classical case, the dissolution of the cocoon transference permits the establishment of a therapeutic alliance. We can say that at the end of this middle phase the patient is emerging from the cocoon—he is beginning to hatch. With this there is a greater sense of aliveness. As patients report it—they feel as if they are beginning to live their own lives.

Third Phase—The End Phase

In this phase the analysis approximates that of a classical case. This is not to say that it is identical to that of a classical case, in that the potentiality for regressive movement is ever-present. During weekend separations for example, there may be a renewal of the cocoon transference. Elements, however, of the historically idiosyncratic transference neurosis begin to emerge —that is, there is a repetition of imagos of whole persons and not the externalization of parts of the self.

We have now entered the realm of the Oedipus complex. In the male, indications of castration anxiety appear in the transference, which has shifted from the conflict with the environment to recapitulate historically determined facets of the transference neurosis. Correspondingly, there is a shift of focus, both within the transference and outside of it, from dyadic to triangular relationships. While the vicissitudes of the Oedipus complex may not emerge as completely as in a "classical" case, they are unmistakably present.

Affects are now experienced with great intensity—now it is only rarely that the analyst experiences the sense of boredom and sleepiness that so characterized the opening phase. In short, during this period the analysis is not unlike that of a classical neurosis, with the exception that there is the readiness to establish a narcissistic affect block that characterizes the cocoon transference.

Because of extreme dependency, it can be understood that the phase of termination may be prolonged. It should be clear that a true termination can be achieved only if the cocoon transference has been resolved through interpretation. In some patients with narcissistic character disorders, this middle and stormy phase in which the cocoon transference is resolved is never traversed. Consequently, the patient remains unanalyzed and persists in a state where the analytic situation itself is used as a transitional object. It can be said with some truth that such patients become addicted to the analytic process.

Empathy and Mutative Interpretation

We have suggested that interpretations only become mutative during the second phase of the treatment of narcissistic character disorders, that is, when there is a state of affective relatedness. Interpretations are, of course, not confined to the second phase of analysis, and we suspect that their therapeutic

action in the first phase may be of a different order. Interpretations may function principally as a sign of the analyst's

empathy and understanding—that is, they may function as part of the analytic holding environment. I believe Rycroft (1956) had something of the same idea in mind when he stated: "In addition therefore to their symbolic function of communicating ideas, interpretations also have the sign-function of conveying to the patient the analyst's emotional attitude towards him. They combine with the material setting provided by the analyst to form the analyst's affective contribution to the formation of a trial relationship, within which the patient can recapture the ability to make contact and communication with external objects" (p. 472).

It is unlikely therefore that interpretations can be mutative until there is sufficient maturation of the ego for the acceptance of self/object differentiation. In the opening phase, the analyst's interpretations, although accurate, may not be distinguished by the patient from the analyst's general empathic response (see also Gedo and Goldberg [1973] for a discussion of the hierarchy of treatment modalities).

The Narcissistic Transference and the Transference Neurosis

It is the underlying assumption in this paper that, as our psychoanalytic nosology is broadened to include syndromes of varying disturbances of ego structure, we will correspondingly have broadened our understanding of the analytic process and the process of transference. This is the point of view developed by Gedo and Goldberg (1973). We believe it is important to resist a tendency to blur the nosological distinction between the transference neurosis and the narcissistic character disorders. We suspect that the increased attention to the narcissistic disorders may reflect an actual increase in their frequency—a shift in the ecology of neuroses—and that a shifting nosology of neurosis may be the manifestation of yet unidentified psychosocial processes. Fenichel (1938) observed that "neurotics who demand analytic treatment today differ from those that went to Freud thirty or forty years ago." And we now say

that the neurotic who seeks treatment today differs from those who consulted Fenichel in 1938. For we have now come to view the capacity to form a transference neurosis as a sign of health. Elements of the transference neurosis

appear only after a certain degree of ego growth and consolidation has been achieved. The development of the transference neurosis requires a capacity for illusion (Khan, 1973). (For a more general discussion of the transference neurosis, see Blum, 1971.) As Greenson has noted (see Workshop, 1974), it is fluid, changeable, and different in every patient. This is in marked contrast to the narcissistic transferences, which are uniform to the extent that they can be said to form an operational basis for defining the syndrome. This is not to say that the delineation of the narcissistic transferences occurs regardless of the analyst's technique or skill. Nevertheless, their uniformity suggests that they are based upon the externalization of psychic structures, that is, various portions of the self, or self-object, and that they do not require a condition of basic trust for their emergence. This suggests that the more familiar externalization of the superego is also a noncreative structural transference element, to be distinguished from the transference neurosis.

Ego Distortion and the Ego's Conflict with the Environment

In his paper, "Neurosis and Psychosis," Freud (1924) suggested that the ego's conflict with the environment was characteristic of psychosis: "... *neurosis is the result of a conflict between the ego and its id, whereas psychosis is the analogous outcome of a similar disturbance in the relations between the ego and the external world*" (p. 149). Our psychoanalytic experience with narcissistic character disorders has shown us that Freud's formula no longer applies, for this syndrome, where the ego is in conflict with the environment, must be categorized as a neurosis. Yet in the same paper Freud suggests a solution to this apparent contradiction, for he states that it is possible for

the ego to avoid a psychotic rupture by "... deforming itself, by submitting to encroachments on its own unity and even perhaps by effecting a cleavage or division of itself" (pp. 152-153). Freud had a specific form of ego distortion in mind, which he elaborated in later papers (1927), (1940). This is the ego's capacity, such as in cases of fetishism, to maintain two opposite views simultaneously, with a resultant loss in its synthetic functions. An example given was that of the fetishist's accurate perception of the female genitals held in the mind side-by-side with the belief in the existence of a female penis. Splitting of this sort, with a loss of synthetic functions, exists in narcissistic character disorders which Kohut described as a "vertical" split.

In our description of the cocoon transference we have suggested that the underlying fantasy of self-sufficiency is defensive and is the consequence of the ego's conflict with the environment. The belief in a state of omnipotent self-sufficiency exists side-by-side with an intense and overwhelming dependency expressed as a craving hunger for admiration and approval. This deformation of the ego is also a split, as Freud described, whose content follows directly from the ego's conflict with the environment. As we have depicted earlier, the specific deformation provides the basis for a specific transference response in which the ego's conflict with the environment is relived in the analytic setting.

We are led to a closer consideration of the nature of the trauma and the resultant ego disturbance or distortion. It would be naïve to suggest that there is a simple or direct relationship between developmental trauma and a specific characterological syndrome. We know of many instances where the developmental trauma is similar and the resultant characterological response quite variable. In questions of this sort Freud (1937) has emphasized the factor of the quantitative strength of the instincts at the time of the environmental trauma, so that it is ultimately a question of inner rather than outer reality.

Further, we know that the reconstruction of childhood trauma from the analytic material of an adult patient is on a less firm footing than our direct observations of the psychoanalytic process itself. Nevertheless, we are not able to minimize the importance of trauma in the etiology of the narcissistic character disorder, which in a very general way may be described as a developmental failure of the "holding environment."

In our patients we can infer through historical reconstruction that there has been a relative failure in the parental holding environment which takes several forms. The child's sense of safety and ultimately his sense of basic trust depends on his reliance on the parents' judgments in their dealings with him and the external world. Intelligent children can easily perceive that their patients' judgment is "off." We were able to determine that several of our patients who suffered from narcissistic character disorders had mothers who were at times childishly fatuous and silly or extremely unpredictable in their judgments of reality. Kohut has described that the mothers of these patients are lacking in empathy and are overly intrusive, an observation we were able to confirm. This failure of empathy can also take the form of a relative failure of the parents' protective function, that is, to protect the child from excessive stimulation. This may mean the failure to protect the child from sadistic or bullying attacks from other members of the household, as well as a failure to

protect the child from excessive sexual stimulation. For there to be a failure of the holding environment, we believe that it is necessary that both parents in some way be involved. We have the impression that in the older child the father's role is significant either in opposing or augmenting the maternal element.

Although the specific form of the failure of the parental shield may vary, we believe there is a common denominator in that it induces the formation of a precocious and premature sense of self, a sense of self that retains its fragility and must be supported by omnipotent, grandiose fantasies (Modell, 1975b). It

is this defensive structure that we see re-emerging in the psychoanalytic processes—the cocoon transference. The conflict with the environment that emerges in the middle period of the analytic process reaches a climax when there is a breaking up of the cocoon transference so that the hatred transferred to the analyst is the patient's hatred of reality.

To return to our question—that of the failure of the holding environment in the "classical" case. Trauma and conflict with the environment are of course not absent in the histories of our so-called classical case, but do not lead to a structural deformation of the ego. We have the impression that such traumas may be reflected in periods of "acting in" during the early phase of psychoanalysis and in the relative abandonment of the therapeutic alliance, as if the patient needs to experience regressively the illusion of the magical protection of the analytic setting. In contrast to the patients with narcissistic character disorders, such episodes do not require any lengthy period of ego consolidation before yielding to interpretation.

It should be clear that we approached the problem of the "holding environment" from several points of view. We believe that there are elements of caretaking functions implicit in the object tie of the patient to the analyst, functions that are part of ordinary psychoanalytic technique. Loewald (1960) has said that the analytic setting represents a *new* object tie. In addition to these "real" elements, there is the fantasy that the analytic setting functions in some magical way to protect the patient from the dangers of the environment, a fantasy similar to that of perceiving the analyst as a transitional object (Modell, 1968). These fantasies commonly appear in the termination phase and are no different from other transference fantasies that can be dealt with by interpretation. In so-called classical cases, the analytic setting functions as a "holding environment" silently; it is something that is taken for granted and can be described as part of the "confident"

transference. Where there is ego distortion, the analytic setting as a holding environment is central to the therapeutic action.

Conclusion

The therapeutic action of the holding environment in the transference neuroses can easily be contrasted to that in the narcissistic character disorders. In the former, the holding environment functions in the manner of a vessel or container that permits the unfolding of the transference neurosis—it provides the necessary background of safety to support illusion. With the narcissistic character disorders, in contrast, the analytic setting facilitates necessary ego consolidation so that mutative intepretations may be eventually effective and a therapeutic alliance may be established. It is only then that elements of the transference neurosis emerge in a form that can be analyzed.

Interpretation leads to the dissolution of magical fantasies associated with the holding environment in a manner analogous to the dissolution of the transference neurosis. If these fantasies associated with the holding environment are not sufficiently analyzed, there is a danger, in the narcissistic character disorder, that the analytic process itself may become a transitional object and the patient would then be addicted to an interminable analysis.

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