In Defense of Long-Term Treatment: On the Vanishing Holding Environment

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There are compelling similarities in the caregiving functions of good clinicians and good parents. Both clinicians and parents function best in a supportive environment. Yet many clinicians do not feel supported. They are under relentless pressure to find ever-briefer forms of treatment for all individuals, regardless of the individual's symptoms or circumstances. This pressure is especially distressing for the clinical social worker who, by tradition, has provided therapeutic services for the most-troubled individuals. This article is intended as a supportive gesture for the clinician who is struggling with questions about long-term treatment. Health care trends and contraindications for short-term therapy are addressed.

A clinical case is presented.

Key Words: brief treatment; health care; holding environment; long-term treatment; psychotherapy

The mental health literature has long recognized the similarities between the role and functions of a good therapist and a good parent. Both the good therapist and the good parent are strengthened when they feel supported and diminished and made less good when their natural talents are undermined by external influences. Only recently have such impingements been inflicted on therapists; parents have been familiar with such pressures for generations.

In 1914, the U.S. Children's Bureau issued the first edition of the bulletin Infant Care (Wolfenstein, 1953). It was a compendium of bad advice. Parents were instructed to have their babies potty trained by eight months of age. They were told that thumb sucking and masturbation, if not rigorously interfered with, would permanently damage their child. They were warned not to pick up their crying child and that such caretaking would turn the child into a tyrant.

Many parents, particularly mothers, were torn between their own instincts and the advice of the child care experts of the day. We can sympathize and easily make allowances for those mothers who, in spite of misgivings, followed these instructions in hopes that their compliance with figures of authority would be in the best interest of their children. It is most difficult to maintain an unsupported position. It is difficult for mothers; it is difficult for clinicians.

The clinician of the 1990s is under relentless pressure to provide ever-briefer forms of treatment for all patients and clients, even though many such individuals have a compelling need for longer treatment. One recent author (Good, 1987) stated that such pressures are symptomatic of what he called "the age of Reagapeutics," in which "brief therapy is symbolic . . . of the modern age in which we do everything intensely and quickly" (p. 8).

These pressures abound. For instance, in a brief article titled "Finding the Right Psychotherapist" published in a widely sold consumer guide (Boardroom Classics, 1989), the first item advises consumers to look for someone who does "short-term therapy" (p. 437). Professional clinicians are
tantalized by articles with sensational titles like “Psychotherapy That Takes Weeks, Not Years” (Michaels, 1989). It is telling that in my computer-generated literature review for this article, I found nearly 300 papers extolling the benefits of brief therapy and fewer than five specifically addressing its limitations.

This steady barrage of such communications cannot help but have an insidious impact on the confidence with which contemporary clinicians approach longer-term, slower-paced psychotherapy. As a consequence clinicians are at risk for caving in to outside pressures, to becoming ever-more involved in the treatment of symptoms rather than people.

How did we get to this point? The trend toward shorter relationships was noted over two decades ago in Alvin Toffler’s popular book Future Shock (1970). He drew attention to the soaring acceleration of change in virtually all areas of contemporary society. One key symptom of this extraordinary pace, he noted, was the ascendancy of transience—the new “temporariness” in everyday life. In particular, relationships that once lasted for long periods of time had ever-decreasing life expectancies.

We can see clear evidence of such trends in mental health. In a simpler time the much-loved Harvard psychoanalyst Elvin Semrad used to tell his students, “If you want to learn about psychiatry get a good suit with two pairs of pants and be willing to sit with your patients until you have worn out the seats of both pairs of pants” (Castelnuovo-Tedesco, 1990, p. 1258). How archaic this statement seems in today’s fast-paced health care market!

Bruno Bettelheim (DeAngelis, 1989) reported a seemingly minor personal incident during his training that had a profound impact on his thinking about treatment and time. At the time, Bettelheim was undergoing psychoanalysis. A disturbed young boy used to sit in the same waiting room as Bettelheim to see the wife of Bettelheim’s analyst, who was one of the first child psychoanalysts. The boy, unresponsive and nearly mute, had the strange habit of plucking and chewing leaves from a cactus plant in the waiting room. As time went on Bettelheim eventually blurted out, “Johnny, I don’t know how long you have been seeing Dr. X, but it must be at least two years and here you are still chewing these awful leaves” (p. 38).

Then, in Bettelheim’s words,

I still do not know how he managed to give me the impression that at this moment he was looking down at me. But he did and spoke his first sentence to me saying disdainfully, “What are two years when compared with eternity?” Johnny’s comment about time permitted me to grasp that neither I nor anybody else can put a limit on the amount of time one needs to become able to cope or to change, and that trying to hurry up the process has more to do with one’s own anxieties than with anything else. Only people themselves can judge when they are ready to change. (p. 38)

What has catapulted such thoughtful, patient approaches to therapeutic treatment into the hurry-up mentality of today’s mental health practice? Among many factors, none has been so influential as third-party reimbursement, a relatively recent artifact that now dominates decisions about the delivery of psychotherapeutic treatment.

From its inception psychotherapy had been financed almost exclusively in a fee-for-service two-party relationship. During the 1960s and early 1970s, however, there was rapid growth in both private and government medical health insurance plans covering treatment for psychological illnesses. As noted by Halpert in 1972,

Many of these insurance plans include partial or total reimbursement, usually up to a certain limit, for treatment in the various psychotherapies, including psychoanalysis. If the trend continues, and all indications are that it will, then even greater numbers of people will be covered for even greater total amounts for psychoanalytic treatment. (p. 122)

Practitioners of that era faced therapeutic problems that we can only wish for. In the luxury of such third-party benevolence, “The anonymous third party, the insurance company, becomes like the anonymous therapist—a transference figure. But the insurance company, unlike the therapist, gratifies transference wishes; it takes care and protects the patient” [emphasis added] (Halpert, 1973, p. 67). Such was the case in the brief Camelot era of psychotherapy reimbursement.

Contrast this with a recent report by Zuckerman (1989) on the effects of managed care on his patient, a 36-year-old, twice married, potentially abusive mother of two who presented with a long history of anxiety and depression. Zuckerman described the patient’s perception of the case manager as a

denyng, ungiving mother, [and this] began to permeate her thinking. When the patient was feeling

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better she became afraid that the case manager, upon discovering her improvement, would feel that she was cured and withdraw his treatment authorization. When she was feeling depressed and hopeless, which was often, she felt that the case manager, upon sensing her lack of progress, would refuse to underwrite any further treatment. (p. 127)

Short-Term Psychotherapy

For decades, theories and methods of one or another form of brief treatment have been formulated, taught, published, and refined. And it has been repeatedly demonstrated that briefer therapies, when used appropriately, are effective.

Briefer therapies are especially useful for the basically intact person who possesses at least a modicum of ego strength, someone who, for instance, adapted reasonably well in life but became the victim of an unfortunate predicament that unduly taxed his or her endurance or rekindled a previously dormant internal conflict. Such treatment is then aimed at relieving a patient’s most pressing symptoms and restoring the person to a state that existed before the acute difficulties (Castelnuovo-Tedesco, 1971).

Longer or more-intensive treatment should never be invoked for trivial reasons. As Stone (1954) once pointed out, “There is sometimes a loss of sense of proportion about the human situation, a forgetting or denial of the fact that few human beings are without some troubles, and that many must be met, if at all, by ‘old-fashioned’ methods: courage, or wisdom, or struggle, for instance” (p. 205). For many individuals, a few consultations or a more extended form of brief treatment is the clear treatment of choice.

Mackenzie (1991), in a comprehensive review of brief psychotherapy, defined four features requiring clinical assessment before considering a recommendation of brief psychotherapy: (1) a capacity to relate, (2) psychological mindedness, (3) motivation, and (4) evidence of adaptational strength. (For years, clinicians have acknowledged the irony that people possessing such strengths make the best use of virtually all therapeutic modalities.) Mackenzie stated that “while [the above] criteria do not in themselves constitute exclusion standards, when a patient is low on several of them, caution should be used in recommending brief approaches” [emphasis added] (p. 401).

As more definitive exclusion criteria, Mackenzie (1991) listed an inability to attend to the process, major characterological features that preclude effective use of the treatment, and the possibility of the patient doing harm. Included here are patients with limited impulse control, a history of repeated suicide attempts, recurrent premature termination of therapy, or entrenched alcohol or substance abuse.

Other patient characteristics Mackenzie (1991) cited that should direct clinicians’ thinking away from brief therapy include the use of defenses that block access to internal states, a dominance of primitive defenses such as projection and denial, major schizoid features, major antisocial characteristics of an enduring nature, and the presence of profound negativism and rigidity. Further, Mackenzie stated that patients with a history of easily triggered suicidal ideation may experience the confrontational qualities of brief psychotherapy as evidence of rejection, and respond with impulsive, self-destructive behavior.

Indeed when any dysfunctional characterological style is deeply pervasive and influences adaptation in many spheres of the patient’s life, rapid alteration is not likely and a course of brief psychotherapy may be viewed by the patient as a further failure. (pp. 400–401)

Yet I recently received a postcard from an employee assistance program soliciting psychologists, social workers, and therapists to provide brief therapy for patients suffering from, among other maladies, alcoholism, chemical dependency, sequelae of sexual abuse, and eating disorders. Brief therapy, as defined by this company, was “up to four sessions.”

D. W. Winnicott and the Holding Environment

Many elements of the therapeutic relationship, as we have known it, are reminiscent of the first relationship between infant and mother. This was first elaborated on in the eloquent writings of Donald W. Winnicott (1896–1971), an English psychoanalyst first trained as a pediatrician.

Winnicott studied and wrote extensively on the characteristics of healthy and unhealthy relationships, particularly early mother-child interactions. Winnicott was repeatedly struck by the parallels in the relationships provided by good-enough parents and those provided by successful analysts, psychotherapists, and social workers. These relationships contained common elements that facilitated development and were created by caregivers devoted to an individual’s unique needs, whether the individual was a baby, a child, an analysand, a patient, or a client.
A central component of this relationship was encapsulated in Winnicott’s (1965) familiar phrase, “the holding environment.” Briefly, the holding environment, as applied to a newborn, is one that is created by a maternal figure who can identify with a baby in a state of absolute dependence and who, as needed, can provide whatever support is necessary—day and night—to meet the baby’s most basic physical and psychological needs. As the infant matures, the caretaker providing the holding environment, while encouraging developmental growth, ensures that the infant is not expected to relinquish its dependent state prematurely.

A similar holding environment can be found in a therapeutic relationship. Modell (1976), while referencing psychoanalysis, makes comparisons. Like the good-enough parent, the therapist is constant and reliable, responds sensitively to the patient’s affects, accepts the patient, uses judgment that is less critical and more benign, is there primarily for the patient’s needs, does not retaliate, and does at times have a better grasp of the patient’s inner psychic reality than does the patient and therefore can help clarify what is bewildering and confusing.

The holding environment helps to foster and does not prematurely challenge an illusion that the patient is protected from the dangers of the world and that the therapist in some way stands as a shield between the patient and these dangers. The good-enough therapist, like the good-enough parent, allows for and tolerates phase-appropriate dependency, all the while looking for opportunities to support maturational thrusts.

Holding, Management, and the Clinical Social Worker

The concept of holding at first may seem intended only for the patient suitable for analysis or insight-oriented psychotherapy. What, one may ask, of the more outwardly disturbed and challenging individual, whose treatment may require more than can be accomplished within a tidy 50-minute hour—the type of client or patient, for instance, who has traditionally been in the care of the clinical social worker?

Winnicott, who frequently lectured to social workers, expanded the concept of holding to encompass clinical management as performed by the trained psychiatric social worker. In a fine paper on case management, Kanter (1990) lamented the current perceptions of case management as an impersonal, administrative service more concerned with cutting costs than helping people in need.

Winnicott, Kanter wrote, used the term “management” to describe direct interventions with the person and the environment that were aimed at facilitating the healing and maturation of even the most troubled individuals.

Winnicott elaborated on the issues of management in a personal letter (Rodman, 1987). He wrote

In social work (as in psychoanalysis) certain factors such as reliability, dependability, and objectivity, provide a specialized environment over a period of time [note Winnicott’s italics] in which the highly complex internal factors in the individual and between the various individuals in the client group may rearrange themselves. The “good” (or I would say “good enough”) climate enables a client to review his or her relationship to climates that were not, or did not seem to be, good (or good enough).

Clinical Example

I began seeing Sue nearly seven years ago. Sue was a white 35-year-old who was proud of her steady employment for the past 15 years at a nearby manufacturing plant. She was referred to me by her daughter’s psychiatrist for adjunctive “parent work.” Her daughter Paula, a deeply troubled adolescent, was doing miserably in relationships at home and with peers and in her school work.

Sue had divorced Paula’s father shortly after Paula’s birth, and she and the girl had since resided with Sue’s mother. The mother, a retired woman, seemed to enjoy the secondary gain she received by virtue of her continual state of seemingly poor health.

Our initial appointment was memorable, if only for Sue’s severe level of agitation. In the session she avoided eye contact, was fidgety, chain-smoked, paced, and nonverbally conveyed her terrible anxiety. As she spoke, taking quick gasps of air between phrases, she repeatedly attempted to assure me that she was not a bad mother. My attempts at gentle reassurance seemed to have only a minimal effect on her anxiety—anxiety that overwhelmed her, causing her to lose her train of thought every few minutes. This caused her great embarrassment, yet her apologies seemed only to make her more anxious. Never in her wildest dreams, she told me, would she have imagined herself speaking to a counselor!

No one had ever known her. To her acquaintances and coworkers she was the lighthearted
clown who could inject humor into many situations, often making herself the butt of a self-denigrating joke.

Yet, as I was to discover, she had a private self with private symptoms. She suffered from periods of both debilitating depression and terrible anxiety. For some years, under the supervision of her internist, she had been taking an antidepressant medication for "nerves" and found it helpful. Although she always managed to function at work, frequently she felt unable to go anywhere there were people and she would spend long periods of time lying in bed in a darkened room. In time she would inform me of her fitful sleep and terrible nightmares: ghoulish nightmares of blood, violence, and murder and of killings involving almost everyone in her immediate family.

Given this situation, it was clear that we could not meaningfully discuss the problems of Sue's daughter without simultaneously attending to her own anxieties. And why this degree of anxiety? But, of course, the answer to this question would simply have to wait. Someone as frightened as Sue would have to be approached gently and carefully.

Sometimes I wonder what I would have reported to a third party had she been in one of the managed-care groups that required preauthorization for treatment. How many would have accepted my true assessment? I was working with what appeared to be a fragile, terribly anxious person who, while not without strengths, was someone with whom I needed to take whatever time necessary to establish an alliance.

What if after a first session or two I had been asked to spell out goals in behavioral terms? Would I have been clever enough to say something true, yet acceptable? And what if I said that my reading of the situation suggested that if an alliance was formed, a big "if" at the time, my sense was that treatment may very well involve years of work? What then? Fortunately, those were not issues I needed to address.

Over the ensuing weeks, Sue's anxiety lessened, we chatted more easily, and I was able to get a better sense of the overall situation in her household. Sue felt caught in the middle between her mother, who she felt manipulated her by playing on her guilt, and her troubled daughter, whose relentless sarcasm inflicted pain on everyone in the household. Sue felt she was an utter failure as daughter and mother and was unaware of any feelings of resentment toward her family.

Early on, I raised the issue with Sue that regardless of what might be troubling her daughter, she had her own share of troubles, and I indicated my willingness to talk with her about them. She did not warm to the idea.

"You're not strong enough," she said. "Neither am I. I look at things different than anyone. I'll be a pain, hard to know. What's important to me is different than others. I have no dealings with anyone."

Soon after, she told me she thought she could be divided into three parts: (1) a clown, (2) someone struggling for self-respect, and (3) someone who is crying and dying.

Six months into treatment Sue revealed that throughout her childhood, since the age of two, she had been sexually abused by her alcoholic father. She related a terrible incident when, at age nine, her father called her elementary school to ask that she be sent home ostensibly to provide care for her ill mother. She arrived home to find only her father, drunk as usual, who took this opportunity to beat and rape her.

During the following years of therapy, Sue began to talk about her early memories. Gradually, there emerged a terrible story of a child who, until mid-adolescence, was routinely beaten, invaded, and humiliated at the hands of a psychopathic father, while an ineffectual mother stood passively by. Each new memory seemed worse than the preceding one and was accompanied by floods of affect which, until then, had been frozen for decades. Sue angrily told me, "The only positive thing I remember my father saying about me was that I was a good cocksucker."

Sue had a rocky time those first few years, as did our treatment relationship. She began to consider her upbringing and its consequences. "I used to think it was just the way things were," she said. "Now it seems so unfair. Not living, just existing, surviving. Never thought about how it affected me. I just said it affected me." Memories evoked grizzly flashbacks involving all her senses. Flashbacks of noxious odors induced marked sleeplessness and severe agitation.

And then came the full brunt of her depression, which in spite of medication increases and changes seemed untouchable. She refused hospitalization and, not unlike her worst pretreatment periods of stress, her life narrowed to work, bedrest, and therapy appointments.

My weekly appointment hour with her, which was typically supplemented with a call or two, was
far and away the most demanding hour of my week. Most of my interventions fell flat, and the key thrust of my therapeutic efforts was aimed at repeatedly telling her, trying to convince myself at the same time, that there was a light at the end of the tunnel, that her depression would not go on forever, and that I would hang in there with her.

Finally things did get better. For most of the next year her mood was considerably brighter and her self-esteem much improved. To her family’s dismay, she began asserting herself and setting limits on their manipulations. She began attending weekly outings at a neighborhood restaurant with friends she had made at work. She became involved in crafts and began receiving recognition awards at local craft shows. Coworkers were delighted to see her return to better spirits, and her employer gave her increased responsibilities in a new project.

But this newfound emotional health was still too fragile to withstand the blow that was to come. Lisa, of whom Sue was especially fond, was the older daughter of Sue’s former neighbor. Lisa, a young woman then in her 20s, revealed to Sue that on several occasions she too had been sexually abused by her own father during her adolescence and at times by her mother as well.

Sue became overcome with rage. The powerful identification she had with Lisa’s trauma left her feeling that if she were anywhere near Lisa’s parents she would kill them. She was unable to sleep for days. Reluctantly she agreed to be admitted to the hospital for what was to be the first of several brief hospital stays.

While in the hospital her flashbacks and night terrors became more severe. She began remembering in even more detail scenes of unimaginable degradation and her father’s threats that he would gut her like a fish or cut off her hands if she dared tell anyone. With the help of a treatment team and a devoted social work intern, she began to talk and write about her experiences and began avidly reading accounts of other trauma victims. She attended art therapy sessions and drew pictures of her memories, including one of a giant headless man with a grotesque erect penis. The man towers over a small naked girl who cries from a face with no eyes. Within weeks Sue left the hospital remarkably stronger.

This is where an author is tempted to end a case report. I wish I could say that she lived happily ever after. But sometimes, in spite of our good work and our patients’ best efforts, things do not go as we would wish.

Sometime the following year, during a family get-together, an argument became heated and a family member lost control and physically assaulted Sue. Once more she was briefly hospitalized, and once more the flashbacks and depressive symptoms returned.

Now, seven years since the start of therapy, I have grown accustomed to the fact that Sue will probably always be vulnerable to such setbacks. During the difficult times she tells me that she has no hope, that she wants to give up, and she insists that I should give up too. She tells me of her nightmares and haunting memories and her burdens of rage, guilt, and self-loathing.

I tell her that I will carry the hope until she feels stronger, and that I am not yet ready to throw in the towel. I extend myself a bit more during these times. Sometimes, at her request, we go outside and walk during our sessions and, when necessary, we arrange additional brief phone contacts through the week. Sue receives additional support and hope from the social work intern who has remained in contact with her, and from her psychiatrist, a devoted health care provider who closely monitors her medication. For the worst times, hospitalization remains an option.

I do not anticipate a change in the treatment plan in the foreseeable future.

Discussion

In my attempt to defend and justify long-term treatment, I could have presented a different kind of case for this article. I could have presented clinical material of someone healthier, of someone, for instance, who credited intensive clinical work with making a fundamental change in his or her life. I could have described someone, for instance, who claimed long-term treatment enabled him or her to save a failing marriage or to leave a hopeless one, to complete an education or change a dead-end career, to get over a developmental hurdle, or to stop the repetition of destructive patterns. There is no shortage of this type of clinical material. We have worked with many such individuals. Indeed, many of us count ourselves among them. A more successful case might have more generously supported the effectiveness of long-term treatment.

After all, Sue is not a typical client. Yet I chose this case because, although it is not typical, it is not altogether rare.

I present this material to support those of us who work in clinical settings and can bear witness
to the steady stream of individuals who come seeking help and whose developmental histories, although perhaps not as severe as Sue's, are nonetheless riddled with abuse, neglect, and deprivation. It seems their numbers are growing.

And many of us continue to hold fast to the belief that the ideal treatment for people who have been failed by human relationships is an enduring human relationship that does not fail. In the words of Winnicott (1987), "In a particular way we can actually alter the patient's past, so that a patient whose maternal environment was not good enough can change into a person who has had a good-enough facilitating environment, and whose personal growth has therefore been able to take place, though late" (p. 102).

**Conclusion**

Winnicott stressed that mothers who have it in them to provide good-enough care can be enabled to do better by being cared for themselves in a way that acknowledges the essential nature of their task. Therapists have similar needs. Like the mothers of decades past, it becomes increasingly difficult for clinicians to trust their own good instincts when their professional institutions, colleagues, and supervisors declare that their devotion to long-term work with a suffering person is theoretically suspect or antiquated.

It is the more difficult to lose this support when the third parties on whom we have—for better or worse—grown to rely for our living become withholding and punitive. Insurance companies that limit sessions to 12 per year, that insist on all-too-frequent case reports and case reviews, influence therapists to mistrust their skills and training and to adopt the insurance point of view in place of their own.

It is a battle for the mind of the therapist, in what Kramer (1990) referred to as the “sentinel effect.” If all goes well in the insurance world, therapists will internalize a hostile sentinel and become suspicious of their own good intentions. The internalized sentinel of the insurance company fans the flames of the therapist’s doubts and uncertainty. A subliminal shift will occur in the mind of the therapist. The limits of treatment covered by an insurance company will gradually be registered in the mind of the therapist as, “This is all the patient needs.”

It is frightening to see where we are allowing ourselves to be led. Kramer (1990) posed the question, "If sentinel effects and restrictions on care cause us to alter our thoughts and behavior—to starve our patients and then see their hunger pangs as whining—how will we act when these pressures are universal?" (p. 23).

What we will see is a naturalistic study of parallel process. As we clinicians feel supported, as we feel held, we could, in kind, support and hold our clientele. As we feel mistrusted, hurried, and pressured, so too will this be transmitted to the people under our care and to our trainees.

In *Future Shock*, Toffler (1970) acknowledged that change is essential but warned that change unguided and unrestrained can overwhelm our defenses and erode our decision-making processes. It is this sort of runaway change, I believe, that is occurring in the mental health practices of our day.

Increasingly, our clinical sensibilities are being molded by the whims and pressures of the marketplace. And the pressures mount. Today’s clinician, interviewed as a prospective provider for an insurance company, is subjected to managed-care McCarthyism. But it is not communism that must be disavowed, but beliefs in a long-term treatment relationship, even though we know, particularly because of our heritage as clinical social workers, that a reliable, enduring relationship is no less necessary for the tormented individual of today than it was for such individuals in days gone by.

We, and especially the next generation of clinicians, stand to lose the clinical wisdom that has been painstakingly accumulated, refined, and passed down from our teachers and supervisors. We must work to ensure that the legacy of this knowledge continues to be transmitted to our students and supervisees.

And finally, we clinicians must maintain and strengthen our connections with each other, individually and through our professional organizations, so that, especially in harried times like these—when so much of the health care world...
seems pressured, confusing, and reckless—we can find for ourselves, among kindred spirits, a holding environment.

References


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