Chapter 10[1]

The Psychoanalyst between Uncanny Reality and Factual Reality

Freud's (1915c) effort to define transference-love ran into a major problem. His declared aim was to help the analyst, faced with intense transference phenomena, to continue to maintain his analytic posture, his self-imposed abstinence and interpretative position. In order to be able to keep his sights on the goals of the analytic process and the ultimate change in the patient, the analyst must not give in to the temptations offered by the transference, be they falling in love or venting his aggression. Freud's attempt to help the analyst maintain his analytic posture under the onslaught of infatuation and eroticized attraction rested on two essential premises: That the patient's love is *unreal* because it represents a *resistance*; and again, that the patient's love is *unreal* because it is a reenacted manifestation of *infantile love*. Freud thus warned the analyst that the phenomenon created, evolved and presented to him in the transference is essentially unreal, a creature of the treatment situation, and therefore must not be yielded to or participated in, but needs to be analyzed.

Freud soon realized the inherent difficulties in this conceptualization: If transference love is *unreal*, can real-life love be said to be "*real*"? And if real love is subject to the same shortcomings as transference love (e.g., repetition of infantile wishes and patterns, and poor or compromised assessment of the love object) – how *un*real is transference love? How can one distinguish between these two loves? Freud reluctantly admitted that real-life love and transference-love are at base not entirely different or easily distinguishable, and that he could not come up with a crucible

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capable of exposing the illusory, pretentious or irrational earmarks of the one compared to the other.

Freud clearly ran into an epistemological problem at this juncture: external reality is both objective and subjective. He, and we with him, must live and deal with the factuality *vs*. subjectivity of external reality; as well as the reality and actuality of our perception and psychic reality. Freud attempted to regain his ground by asserting that "we have told our patient the truth, but not the whole truth" (ibid, p. 168). Nonetheless, we are left with a number of unresolved dilemmas: Is *everything* that transpires in the treatment a product of the transference? Is there a place within the analytic situation for the impact of so called "reality"? What is the role of the analyst *vis-à-vis* the manifestations and intrusions of external reality? How is he affected by it? To what extent should, or should not, the analyst set himself up as the arbiter of reality? And what is the price exacted for taking such a position in terms of analytic neutrality and abstinence?

There have been numerous subsequent efforts to deal with the proper place of external reality within the analytic situation (e.g., Greenson & Wexler, 1969). There are, however, two situations where we expect the impact of real life events to be uncontroversial and beyond subjectivity: external trauma, and life under terror attack. In what follows, I will attempt to examine the impact of these two impingements (which may be one and the same, but can also be quite different) upon the analytic space. I will try to demonstrate that Freud's dilemma holds true for these impingements as well, that it is very difficult to establish clear lines of demarcation, and that just as with transference-love, though for different dynamics and reasons, the impact of terror and trauma severely taxes the analyst's capacity to maintain the analytic position, space and setting.

I begin with a personal vignette. During the Gulf War in 1990-1991, Israel was faced with the threat of Iraqi missiles carrying chemical or biological warheads. No one knew for sure whether such warheads existed, or if Iraq had the capacity to deliver them, and the unknown fueled and amplified fears and fantasies. We were ordered to carry gasmasks and to set up and take refuge in “sealed rooms”. For several tense and anxious weeks most people complied with these instructions, which eventually turned out to be wrong and perilously misleading. When the air-raid sirens sounded, we would grab our gasmasks and hurry to the shelter of our “sealed room.”

The consulting rooms of many analysts and psychotherapists in Israel are in their homes, and so a new and unfamiliar dilemma emerged: The “sealed room” served the family, often with relatives and friends who came to take refuge. These rooms were typically very small and crowded, people were emotionally upset, often not fully dressed, small children cried and balked, and the stay could last for hours on end. It is not hard to imagine that it was not the kind of situation one would want to be in with one’s patient. Nor could it be particularly comfortable for the patient, although (or because) it might gratify the wish to observe one's analyst and family in a “private” and intimate setting.

At this point I had an experience from which I learned a great deal. Faced with this dilemma, and given my analytic understanding at the time, it appeared to me at first unthinkable to introduce my patients into our family’s small sealed room. Instead, and as a "solution" to my dilemma, I bought a “sealed suit” which I offered – fortunately – only to one patient. Her reaction was deeply instructive: She was hurt and shocked – not because I would not let her into my “private space” with my family, or because what I offered her was inferior to the sealed room, but because it meant that if anything happened I would rush off to be with my family and leave her

alone in my consulting room. This was something for which she severely – and rightly – chastised me. On reflection, I agreed with her. It highlighted and helped me to frame my conflict: To remain with my patient or to be with my family under the threat of trauma and disaster? It brought into focus ethical dilemmas concerning professional and personal responsibility, loyalty and dedication. It also illuminated the fragility and tenuousness of the psychoanalytic situation, and the need to reconsider what is meant by the 'psychoanalytic space' under attack and in times of terror.

Before I attempt to consider the nature of the psychoanalytic space, it is important to delineate the different levels of impact and suffering incurred by a traumatic terror attack. The brunt of such a terrorist act can be charted in several concentric circles: The first circle is the impact on the *direct victims* of the attack who suffer personal injury, or the loss and injury of someone close. The second are those who become victims through *witnessing* the act of terror. The third are those traumatized by working with the victims, who are often themselves in need of help. The last circle comprises the *entire society*, affected by shock and anxiety, and resorting to a kind of “active passivity” – people anxiously restrict their normal movements, worry about themselves, their children, their relatives and friends, and are frequently unable to work and concentrate.

Working with the first of these three circles is the difficult task of attending directly to the victims of mass traumatization, which I will not discuss here. My present remarks are based on my own and others’ experiences in daily psychoanalytic and psychotherapeutic practice with the last group – those *not directly affected or traumatized*. They come to sessions after or while bombs are going off, sirens blast and attention is riveted to radio announcements of casualties and figuring out the whereabouts of relatives and friends.

My practice in Jerusalem is near Mount Scopus Hadassah Hospital and the National Police Headquarters, overlooking a major road. Sessions are frequently punctured by sirens of ambulances and police cars rushing to and from an accident scene or a terror attack. My patients and I have learned that more than three separate, consecutively heard sirens could signify that a terror attack has taken place. External reality has impinged upon the psychoanalytic space.

The Nature of Psychoanalytic Space

"The psychoanalytic situation," writes Arlow, "is perhaps the greatest and most original of Freud's contributions to the study of human psychology" (1987, p. 382). …What may be unique to the psychoanalytic situation is its capacity to lend itself for use as a "potential space" (Winnicott, 1971), an intermediate area of experience in which people may allow themselves altered states while being "held" by the analytic setting and the presence of the analyst, a transitional area of experience that is felt as both self and not-self (Bromberg, 1996)" (in Aron and Bushra, 1998).

The 'psychoanalytic space' is a *creation* of its two participants, who transform the psychoanalytic *situation* into a psychoanalytic *space* (Viderman, 1979). It makes use of the interplay of forces, motives and intentions so as to fashion a context of meaning and understanding that may potentially serve both. The psychoanalytic space is nowhere to be seen, yet is a psychic reality.

Psychic reality is not divorced from external reality. At base, it is the elaboration of our perception and construction of physical reality under the sway of internal forces. Modestly put and practiced, it is a *transformational* mode that analysts apply. We become "experts" at transforming concrete physical facts into meaningful psychic experience.

Differentiating Individual from Communal Trauma

There is a profound difference between an individual trauma and a trauma that befalls a community. An individual who sustains a trauma always experiences it as uniquely personal. If, however, the individual trauma is part of a communal one, it uniquely informs, transforms and shapes the experience of trauma. The impact on the psychoanalytic space of horrors like 9/11, or daily terror-ridden existence in Israel and elsewhere, is different in a number of essential ways from a privately sustained trauma, such as being robbed, raped, in a car accident or losing someone close. Quite unlike the typical individually sustained trauma, which has not directly affected the analyst, we are dealing here with *traumatized communities and societies to which both patient and analyst belong*. The traumatic impact and its understanding must therefore partake of the dynamics of group and social processes. Several consequences are immediately pertinent and notable:

1. As members of the traumatized group or society, the trauma affects *both* analyst and patient.
2. The traumatic experience re-defines external reality – it provides a new, commonly shared and socially validated basis for post-traumatic existence.
3. The shared traumatic experience creates new group identifications and social affiliations. These new affiliations are based on the commonly experienced trauma, as well as on shared survival guilt, depression, reparation, and shared hope.
4. The newly drawn up group affiliations and social boundaries are potentially problematic for both analyst and patient. It presents them with a seeming choice between acknowledging this externally imposed new “camaraderie” and closeness as against resisting and denying it.

5. Analyst and patient may find themselves on opposite sides of the political and ideological fence, blaming and holding each other "responsible" for the traumatic situation. An Israeli illustration of such countertransference issues is when the analyst is identified with the political Left and Peace Movement and the patient is a Right Wing Settler living in the occupied territories. While such issues are always present, they may be dormant and confined to the background. The common trauma suddenly and forcefully thrusts them into the foreground.

The Presence of Terrorist Acts in the Analytic Space

There is an assumption and a commonly held expectation that the impact of terrorist acts must be present in the consulting room and it permeates everything. The peculiar fact that I and many colleagues have observed, however, is that many or most of our patients do not speak much, or not at all, about the traumatic events. This is certainly not readily understandable and seems puzzling. It is reminiscent of Winnicott's wartime experience, when he "hardly noticed the blitz, being all the time engaged in analysis of psychotic patients who are notoriously oblivious of bombs, earthquakes, and floods" (1945, p. 145). But I am not speaking of psychotic patients. Perhaps when external reality is psychotic, the psychoanalytic space becomes a haven of sanity and personal integration. A further possibility is that some analysts are more 'inviting' to talking about external reality and real life events than others.

I have tried, mostly in vain, to decipher clues to the external events in sessions following particularly horrendous attacks. Patients may refer briefly to the horrible situation at the beginning of the session, and then delve into what "really" bothers them. Only rarely is this accompanied by guilt for attending to their private concerns and pains. I am not suggesting that they are impervious to the terror attacks. I am suggesting that, as in any analysis, the boundaries between what might be called

"external" and "internal" are extremely fluid, shifting and personal. Let me briefly illustrate this with a few vignettes.

1. A woman in her 50’s came to her analytic session minutes after a car bomb exploded on a Jerusalem street, killing two innocent passers-by. Her daughter had just moved into an apartment around the corner from the blast, and all her windows were shattered. She started the session shakily with this fact, expressing both concern and relief. Usually she is very anxious about this daughter – her need for autonomy, her relationship with her and with men, etc. The real external danger, however, briefly acknowledged and gratefully put aside, seemed “unreal” or uninteresting in comparison to her lasting internal concerns. At a deeper level, there may have been an unconscious link between her anxiety and her aggressive feelings about the daughter's growing autonomy, which for a number of reasons could not be pursued at this stage.
2. A highly narcissistic young man came following a weekend of violence and terror attacks which he did not mention. He spoke of the chaos in his life and space – the state of his car, home, and studies. He wants to study philosophy, which encompasses everything, but lacks his father’s capacity for total dedication. He searches for an idea he can link with, with which he can "go all the way". He wonders whether I can understand any of this. Perhaps it is best to give up on life? Yet to live the way he does *is* to give up on life. As I listen to him, I am thinking about the terrorist mind (Erlich, 2003a; see Chapter 11), and I find parallels between my thoughts and what he says. I point out his great need “to go all the way,” to find and cling to something “pure” and larger than himself amidst the chaos and the mess, and his life-long dilemma of “living and yet not being alive.” The actual terrorist act is never mentioned by either of us, but seems to hover in

the air. In a later session he speaks about his frequent regressions and perverse setbacks and says: "These collapses are just like a terrorist act – there is no way to control them."

3. An obsessive, depressive, guilt ridden, middle aged man felt pleased and happy during an unusually sad and difficult week with an unprecedented number of dead, both Israeli and Palestinian. His wife said that he must be the only happy person in Israel. His professional work brings him in contact with people and issues on both sides. Somewhat intellectually, he interpreted his good mood as “unrealistic” and crazy, and attributed it to his neurotic issues: the horrible external circumstances relieve his internal guilt. He had been involved in talks with leaders on both sides and actually marveled at their sanity. I suggested that, far from serving mere neurotic needs, he carried within him a tiny bit of sanity and hope, derived from his actual experience, and not available to others. He could see that if more people had his particular experience they might well have shared some of his optimism and good mood.
4. A highly intelligent, creative and neurotically depressed man stepped outside his academic ivory tower to become politically involved. His activities led him to actually line up with Palestinian farmers against brutal attacks by Jewish Settlers. He risked his physical health in these activities, but felt greatly involved and satisfied. In the analysis he questioned and explored his political activity. It seemed to have multiple meanings, such as standing up to his father and not masochistically submitting to him or to the authorities. It also expressed his rage at me, as well as feeling morally superior to my seemingly more neutral and uncommitted political stance. The analytic work kept to these familiar oedipal

themes and interpretations, yet clearly the external and internal realities became closely and deeply joined for him.

While these vignettes differ widely from one another, they all take place against the common background of external horrors and terror. Yet they deal with external reality quite differently: The first patient acknowledges it briefly and proceeds to her internal concerns. The second patient never consciously or manifestly refers to it. Yet, symbolically and unconsciously it is present in his yearnings for a larger-than-self, "pure" state with which he may fuse, without which life is not experienced fully. I see this quest as intrinsic to terrorist acts (Erlich, 2003a) and it may readily be stirred up in those who, because of their personal pathology and makeup, resonate with it. The third patient openly relates to external reality, but prefers to interpret it in line with his neurotic conflicts and intellectual defenses. My interpretation expanded this so that he might feel less isolated and more a part of society, yet with his unique experience and voice. The fourth patient freely brings his involvement with an aggressive and dangerous external reality into the analysis, where it symbolizes his transference dynamics and can be interpreted along these metaphoric lines.

These vignettes are not meant to represent definitive varieties or methods for dealing with a terrible external reality. They illustrate and underscore the endlessly rich and baffling variety in which external reality finds its way into and can be worked with in the psychoanalytic space. This 'space' is clearly not a fixed and concrete entity offered to all four patients. In each case, it is the unique space created by the specific pair. The analyst takes full responsibility for its creation and maintenance, but only partial responsibility for its unique color and texture. External reality is treated and appreciated differently in the context of each unique psychoanalytic space.

Meaning is generated not by the *facts* the patient relates, or by the actual external events, but by the capacity of both patient and analyst to relate to these facts in an imaginative and *not* fully realistic manner. New meaning develops not from what is familiar, understood and taken for granted by both analyst and analysand, but out of what is uncanny, puzzling, and inexplicable.

The Analyst's Responsibility for the Patient's Welfare – Real or Imaginary?

The psychoanalytic space is the quintessential expression of the analyst's technique and skill. Both ethically and technically, it epitomizes the analyst's responsibility – to do his best to help his patient to explore and integrate external impingements with internal motives and fantasies. But additional questions present themselves: The assessment and responsibility for continuing with the psychoanalytic work in the face of dangerous conditions; the relative share of responsibility borne by analyst and patient for what may happen to either one or both; and the technical questions that come up as a result. For example, if traveling to and from sessions endangers the patient who has to cross danger zones – should the analyst draw attention to it? Is it solely the patient's decision to continue to come? What if coming to sessions becomes self-destructive? Do we charge patients for sessions missed under dangerous circumstances? When do we collude with the patient's aggressive fantasies, or with fantasies of his, or our own, indestructibility and invincibility? How far does our responsibility extend in "allowing" or "forbidding" his coming to see us? Do we invariably regard coming to therapy and analysis as the most sane and constructive course?

My Gulf War example highlights what has become my own ethical and professional stance: As long as I practice and invite patients to come, I am there for them and responsible for their welfare while they are with me. My understandable

conflict between being with my family or with my patient was thus misplaced: My primary commitment, so long as I am practicing, is to the patient, and not to my family. It is the essence of my professional stance and responsibility. If I must change this commitment in order to be with my family, whether to protect or to seek protection, I should temporarily take leave of my practice. I certainly should not saddle my patients with my conflict. The dilemma consists in whether it is possible to continue to be a therapeutic container and to maintain the psychoanalytic space under such circumstances. Obviously, this dilemma does not permit a standardized answer and resolution, and must be borne in mind by each analyst under the specific circumstances that hold sway.

Fraternity under the Threat of External Danger

The jointly experienced external threat, and the joy and guilt aroused by the realization of common survival, give rise to feelings of camaraderie and brotherhood in both analyst and patient. A special bond is forged between them by having lived through the same horrendous events, thus becoming "brothers in arms." In analysis, this fraternity may set in motion a flight *from* the transference into factual reality, which paradoxically may lead to undermining the 'psychoanalytic space.' At the same time, the analyst has to be ready to acknowledge the disconcerting events that both he and the patient lived through. This is a fine line that needs to be walked with warmth, understanding and sympathy, but at the same time, without the loss of overall analytic purpose and task.

Quite understandably, the analyst may feel the need to "share" his experience and derive comfort from the patient. We do not speak enough about the loneliness of the analyst (Erlich, 1998). To create and offer the analytic space is an act of generosity that may leave the analyst feeling alone and isolated. Our patients can then

serve as our link to the outer world and social reality. They supply information, human presence and a sense of community. During periods of external threat and disaster, when our loneliness becomes unbearable, this need greatly intensifies, rendering us more prone than ever to needing and using our patients as connections and channels to the outside world.

In order to create, maintain and be fully present in the psychoanalytic space, the analyst develops the capacity to temporarily suspend his ordinary human need for contact with external reality. This suspension is in the service of greater openness to the uncanny, the horrible and the unbearable in internal reality. But this extraordinary capacity has its limits. The analyst must also respect and attend to his need for maintaining contact – with factual reality, with family and friends and his social network. Treating this need disrespectfully, out of an inflated sense of grandiosity and therapeutic omnipotence, may lead to having it fulfilled and satisfied through one's patients. This is exactly what Freud warned against in his paper on transference-love.

In Conclusion

As analysts we are keenly attuned to a portion of reality that seems impractical and non-pragmatic to others, the stuff that dreams are made of. My aim in these reflections is to draw attention to the impact of the harsh and cruel realities of terror and violence on analysts as well as on patients, and on the space in which we meet and work together. In light of these reflections, do we need to alter, modify or amplify the psychoanalytic space or our technique? Or have these already been altered by the external conditions in ways that need to be acknowledged and explored? In my view, it is not the psychoanalytic space that is in need of revision. In the face of horrendous external realities, it should actually be maintained and reinforced, for it serves a purpose and function that nothing else can or does. But we do need to be alert to the

complexities, the dangers and social dynamics within which we operate. We must attend to what is *actually* presented by the patient and his psychic reality, and guard against imposing our view of reality as dangerous, cruel or benign on our patients. This, I think, is also the essence of the psychoanalytic stance and ideology.

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