Fear and Shame in an Israeli Psychoanalyst and His Patient: Lessons Learned in Times of War

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Living in the midst of a war presents unique challenges to ongoing psychotherapeutic treatment. This paper focuses on the ever-present threat of fracture to the analytic frame and the limited ability of the therapist to create a safe, insulated environment—a reliable container—in which to work, while coping with a violent external reality. Using an intrapsychic lens, as well as an interpersonal one, the dynamics of both the analyst’s and the patient’s fear and shame are brought into focus. This delicate balance is illustrated through two cases: one occurring during the First Gulf War (1991) and the second taking place during the Second Lebanon War (2006). In both cases, fear and shame cause a stalemate in the psychotherapeutic process. The analyst recalls his active duty as a soldier during the Yom Kippur War (1973). These memories and their attendant acknowledgement of fear and shame by the analyst, as well as his analysand’s “supervisory” comments, gradually dissolve the knot and repair the rupture in the analytic process. The ability to fully experience fear, shame, and helplessness is at the core of psychic health, a health once destroyed by dissociation and denial of these feelings. This ability to experience fear and shame is the psyche’s antidote to mental breakdown. Following discussion of the two case studies, this paper seeks to illustrate how the very structure of a society, in this case Israel, can codify societal defense mechanisms against emotions like fear and shame, exacerbating the very problems it seeks to assuage.
INTRODUCTION

Aiming to keep the discussion as “experience-near” as possible, the material in this paper is purposefully presented in a relatively raw form. When we suggest tentative formulations or draw generalizations, we do so from a stance of what we have come to refer to as “clinical theory.” We present several clinical examples of therapy during war. In our exploration of these cases, we discuss the fears and shame of the therapist as well as of the patient. In addition, we examine what happens to the frame and to the psychotherapeutic process during war times.

A substantial body of authoritative work has already been written on trauma and posttraumatic disorders. We do not address these subjects here; rather, our main focus will be on the manner in which the relationship between the therapist and patient is affected by the war’s perforation of the analytic setting.

Finally, we turn our attention to the social perspective, exploring the ways in which the social narrative influences therapy. Using Israeli society as our example, we attempt to demonstrate how defense mechanisms operating on a wide social level play a hidden role in influencing the abilities of both therapist and patient to contain fear, shame and other painful emotions.

The war between Israel and the Palestinians, as well as the larger conflict between Israel and its Arab neighbors, is, regrettably, still raging. Israelis are therefore living in extreme adversarial circumstances. Yet for many years parts of the psychoanalytic community in Israel were, to a certain extent, oblivious to the influence of the adverse circumstances of war on therapy. This paper discusses the dilemmas of psychoanalysis in a unique context: that of Israel as a society fearing war and terrorism. However, the questions this paper explores regarding the role played by external reality in therapy are becoming increasingly relevant in a broader context, as terrorism becomes a serious concern for every member of Western society.

In the past, psychoanalysts were trained to see the external reality as nothing more than a shadow of internal reality. As recently as a quarter of a century ago, an interpretation that offered castration anxiety as an explanation for the fears and anxieties of soldiers who were traumatized in the First Lebanon War (1983) was plausible by at least some analysts. Other analysts, who had already been influenced by the writings of Winnicott, Balint, Kohut, and Laing, interpreted the fears and anxiety of the soldiers as existential threats. In order to recall these events, we had to pass through the hazy forgetfulness which served as shield to our self-esteem. Today it sounds like a caricature of psychotherapy, but at that time our horizons did not extend further than the strict intrapsychic ultra-orthodox model of mind. As Ludwig Wittgenstein would have put it, “the limits of our language are the boundaries of our world.”

We would like to share two vignettes, taken from Michael Shoshani’s practice. The first took place during the First Gulf War (1991). In this case, the therapist did not acknowledge the fear and

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1This is the first, but definitely not the last, time that we touch upon the feeling of shame in this article, and we are reminded here of Nietzsche’s (1966) deep wisdom: “I did that,” says my memory, “I could not have done that,” says my pride, and remains inexorable. Eventually—the memory yields” (Beyond Good and Evil, Aphorism 68). Out of therapeutic experience, and using the writings of Ferenczi, Fairbairn, Sullivan, Balint, Winnicott, and Kohut, psychoanalysis was able to recognize the importance of the external reality and the impact of external traumas on development. There are vital psychic events that cannot be fully explained and conceptualized as results of intrapsychic complexes and conflicts. In recent years, we have learned from the Relational School and the Self Psychology School that the sharp distinction between the internal and external realities is a false dichotomy: the two are integrated and co-constructed, creating one combined fabric.
shame he was experiencing as a result of the war, nor did he recognize the interference of his personal concerns with the therapy. This state of affairs resulted in a deterioration of Shirley’s emotional state, leading to a breach of trust between patient and therapist. The second clinical example took place during the Second Lebanon War (2006), during which a different patient exhibited an attitude of haughty disregard towards the dangers of the war, resulting in a countertransference that caused a stalemate in therapy. Naturally, the treatment that took place 17 years ago is not as detailed and extensively discussed as the second analysis, which is an ongoing treatment. Still, we believe that the first example highlights some important issues pertaining to the practice of psychotherapy during war.

SHIRLEY AND MICHAEL: PSYCHOTHERAPY DURING THE FIRST GULF WAR (1991)

The first example of the invasion of outside reality into the therapeutic space occurred during the First Gulf War (1991). This war was the first in which the Israeli civilian population was under direct attack by long-range missiles from Iraq. The situation was aggravated by the widespread belief (at the time taken as fact) that some of the missiles’ warheads were carrying chemical nerve-gas substance. Neither the Americans nor the Israelis were able to find a suitable defense against this threat. Large segments of the Israeli population were further terrified because of their associations of weaponized gas with the Nazis’ use of gas in the death camps during World War II.

During the first 2 weeks of the war, the missiles hit Israel frequently, forcing many Israeli families to spend hours of every day—and especially every night—either in a shelter or in an insulated room. Tensions were high, because no one knew whether the next missile to hit would carry a regular explosive discharge or nerve gas.

I remember walking every morning to my office (5 minutes’ distance from my home) and feeling that in some senses, everything was the same. The streets were the same; the buildings were the same; my office was the same; the books, chairs, and desk in my office were the same; and my patients and I looked the same. Yet, nothing was the same; a strange feeling of unreality accompanied everything. With my every move, I felt as if I were looking in a mirror, recognizing that it was I, yet not feeling that it was I. I had the strange feeling that I was faking being a psychologist. Only weeks later could I name those feelings as derealization and even depersonization. But at the time, I was aware only of feeling that the floor was moving under my feet and that my ontological anchor had been dissolved. The frame of therapy had been shattered. Reality had brutally and violently violated the usually secure therapeutic space. My ability to be in a therapeutic stance, largely putting aside my worries and concerns and giving priority to the patient’s needs, had been severely compromised. I felt very confused and dislocated.

FEAR AND SHAME

2Because of Michael’s very personal experience, the two case studies are presented in the first person. One of my patients at that time was a middle-aged woman named Shirley, who had been in therapy with me for 2 years. Shirley, a difficult-to-reach patient, was not interested in talking about the war, as if it were not really happening. She was very preoccupied with telling me about a conflict she had had with some of her friends at work, relaying a quarrel she had had with her mother, and complaining about her doctor (GP) who was not attentive enough to her complaints about her sore throat. She said that she was practically mute and that he did not help her. I remember thinking that this doctor who did not listen to her was, in the transference, probably me. I should have tried to help her find her “voice” since she was “mute,” but my ability to fulfill this role as her therapist was compromised because of how the war was affecting me.
All Israelis were required to carry gas masks, given the imminent fear of chemical missile attacks. As the days passed, I noticed that I was moving on a continuum from closeness with to distance from my patients at a pace that was out of character for me. I have learned that since the beginning of the war, I tend to get closer to my healthier patients while I tend to distance myself from the more disturbed ones.

I remember it was quite difficult for me that she did not want to talk about the war. I told myself that her refusal was perfectly legitimate and that her inner catastrophe was the real arena in which the war was taking place. Yet I had a strong desire for us to “be in it together.” I think I needed an explicit recognition, that although our reality seemed superficially unchanged, this appearance was merely an illusion (I think American psychotherapists and psychoanalysts had similar feelings after the September 11th attack). Thus, as I see it now, I believe that during the first 2 weeks of the war I was only halfheartedly with Shirley and was not able to listen to her the way I used to.

In one of our sessions, the siren went off, suggesting that another missile was about to land. Absurd as it may sound, both Shirley and I, sitting in my secured and insulated office, put on our gas masks and pretended to go on with the session, as if it were “business as usual.” This attempt soon failed, as it was almost impossible to talk and listen through the masks, especially as the circumstances were extremely distressing. The minutes wore on, as both Shirley and I waited for the recognizable, eerie sound of the missile hitting the city. Yet, while scared to the bone, we both carried on the façade, as if the outside reality could not invade our imagined cocoon. During the next session, which took place the very next day, Shirley demanded in an angry voice to know what I would do if a missile hit nearby: would I stay with her, helping her cope with her stress and terror, or would I abandon her to take care of my family? I had to admit to myself that Shirley’s concerns were justified, as I was indeed preoccupied with thoughts and fears about my family. I felt surprised, uneasy, perplexed, ashamed, and guilty because of the terrible dilemma into which I was placed. I did not have the space for exploring this complex emotional issue with Shirley. I felt I had to give her a concrete and honest answer; nothing else seemed appropriate at the time. Therefore, after deliberating briefly, I told her that I felt myself to be facing a terrible dilemma because I truly did care and worry about her, and I understood that if I were to leave her alone I might harm her. I explained that, at the same time, I was concerned about my family, and I owed it to myself as well as to them to go and verify that no harm came to them. Shirley interrupted me, shouting, “What do you mean, dilemma? You are telling me there is a concrete possibility that you would leave me to go take care of your family. So don’t tell me any stories! In my wildest dreams, I did not imagine that you would desert me.” As soon as the sirens had gone off I had been reminded that, at least once or twice since the war began, I had been semi-aware of fleeting thoughts about bringing up with Shirley what would happen if a missile landed nearby, and the difficult dilemma it created for me. I regretted not discussing this dilemma with her earlier. When Shirley voiced her angry question, it became clear to me that I had suppressed these thoughts because I was unable to discuss them openly.

For the opposite position, see Melanie Klein’s (1961) Narrative of a Child Analysis, where she talks about her analysis of a young child during World War II where she analyzed the patient when bombs were dropping not too far from where she lived. Klein leaves the reader with the impression that it was business as usual as far as her psychotherapy with the child was concerned, as though external reality did not exist.
Reflections on the Issues of Fear and Shame in the Treatment of Shirley

The reasons for Shirley’s and my behavior during this incident—her fury at my potential departure and my failure to broach that same subject with her earlier—were not clear to me at that time. It was only later that I realized that Shirley and I had split and dissociated our fearful and shameful parts, making them into “not-me,” each of us as a result of his own emotional constellation.

Shirley was deserted at the age of 4, after a violent divorce. She was left with her father while her mother abandoned her. The picture Shirley had drawn in the 2 years we had been working together was of a girl, and later on of a middle-aged woman, who had always been alone. Over the years, for short periods, she had some connections with colleagues at work, and, very rarely, she had sexual relations or romantic relationships. She lived on her own for many years and kept to herself, rushing in and out of her apartment so there would be as few interactions as possible with the neighbors. I have no doubt from my acquaintance with her that for her, contemplating the possibility of my deserting her (going to take care of my family) was inconceivable and intolerable. Even before I had finished telling Shirley my decision, she started crying and shouting at me, telling me that she was terminating the treatment at the end of that session. I remember two thoughts competing for my attention. First, I wondered how I could have been so insensitive as to not bring the issue up during the first days of the war in order to work through it with her. My second thought was that one scenario existed that was even worse than what had just happened: the scenario in which we would not have discussed this alarming dilemma at all and I would have had to leave her to take care of my family without having prepared her for such an eventuality. This scenario might have led to the termination of the treatment and might even have brought on a psychotic break.

Shirley’s surprising question was, in my opinion, not an act of courage or of overcoming fear. Her question was a result of the brutal reality of war and the shattering of the reliable container of the therapy, which perforated Shirley’s shield and would not allow for continuation of the dissociation that Shirley had used for many years. Months later, when Shirley’s anxiety subsided and her rage towards me as a “deserting mother” was more containable, and in a way one could say that both of us, Shirley and I, could forgive my not being a good-enough therapist during the time of the war. One of the results of this forgiveness and reconciliation between us was her ability and wanting to tell me what she had gone through at that time. She told me that during the first 2 weeks of the war she had had multiple flashbacks and memories of her very early years in which her father and mother violently argued and she was left alone, crying and scared. She even remembered times when such violent outbursts between her father and mother ended with her mother leaving the apartment and slamming the door. Once again, she was left alone and terrified. These flashbacks and memories were never brought up and discussed in the sessions prior to the crisis in our relationship.

Gradually, I came to understand that Shirley’s crying and shouting were clear signs that I was witnessing a retraumatization of Shirley’s abandonment by her mother at the age of 4. It seemed that Shirley’s fragile self—her “me”—had to face and cope with a dissociated “not me” that had returned to the psychic stage and threatened an imminent mental breakdown. What was happening was not that I in the transference was like her mother, but that I was actually the mother. The potential of my leaving her and going to my family was not a symbolic desertion; rather, for Shirley it was a reliving of the actual desertion.
The encounter between Shirley’s traumatic desertion in the past, and my potential “desertion” in the present, could have created a valuable, health-enhancing opportunity for working through Shirley’s trauma. To paraphrase Benjamin (2004), if I had been the first one “to go,” that is, if I had brought up this anxiety-provoking situation and had shared Shirley’s terror, we would have been better prepared. In this scenario, our working through of the issue would have allowed Shirley to begin regaining and reowning parts of herself she had disowned many years ago, instead of experiencing a violent intrusion of the “not me.” We would then have managed to separate the time periods in such a way that the past would have remained an experience in the past, and, consequently, the present would have started “becoming the present,” which in turn would have made possible an open door to the future. But instead, because of the retraumatization of Shirley’s original catastrophe, the time periods became confused into one time period—an everlasting present. At that stage, I could not help Shirley transform the “severe anxiety” of desertion into a more containable separation anxiety.

For many weeks and many more sessions afterwards, I was preoccupied with the question of why my eyes had been “wide shut,” why I had turned a blind eye to what was in fact directly in front of me. My absence had been so bluntly present. Shirley’s traumatic desertion as a child had always hovered in the background of our sessions, and now, with the onset of the war, it inched closer to the forefront of our discussions. Yet it was never contained and verbalized by me.

Over the years, I have come to understand my failure to be a result of two major configurations. The first related to an incident I had with my analyst. In 1991, during the First Gulf War, I called my analyst (after 7 years of psychoanalysis) on the night that the war began and a missile landed in Israel. I remember he was very terse and business-like over the phone. The next day when I came for my session, I was questioned, but more so criticized, for calling him at home. He told me that I did not respect his privacy and said that I was trying to destroy the framework of the analysis. He added that this was another example of my difficulties accepting the boundaries of our relationship.

It took a few years, a second analysis, and the experience of patients calling me during the next war in Israel—and my own countertransferring reaction to their calls—to figure out that I was not the perpetrator in the incident with my analyst but the victim. At the time, I was not aware of my emotional reactions to this interaction with my analyst, nor did I comprehend the significance of the events. As Freud’s famous saying goes, “If you don’t remember, you tend to repeat.” I believe this statement is applicable not only to memory but also to the comprehension of the emotional significance of certain events. I did not grasp the full meaning of how hurt, shamed, and humiliated I felt in reaction to my analyst’s blunt rejection. This unconscious construction of my relationship with my analyst repeated itself with Shirley, this time with the tables turned. I was not the passive-rejected party anymore, but the active-rejecting one (the process of the identification with the aggressor was already unconsciously on its way). Again to call on Freud, the gap that cannot be memorialized and grasped is bound to repeat itself in an action. One should note that in this incident I am not referring to my analyst’s personal characteristics—his warmth, his kindness, and so on, or lack thereof—but rather I am referring to the classical analytic stance itself, about which Ferenczi had already warned that it might be interpreted differently by different patients: By those

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4See Sullivan (1953).
patients who have been traumatized, this analytic stance of technical neutrality can be interpreted and experienced as rejection, indifference, and desertion. My analyst was a firm believer in the classical stance and acted accordingly, and I as Ferenczi had predicted, felt rejected and deserted.

The second configuration that I believe had a significant influence on the impasse in Shirley’s treatment related to my unsettled emotional stance during the first 2 weeks of the war. For the first 2 weeks, everything was falling apart for me. I was confused and disoriented; I felt that my usually solid reality was crumbling in front of my eyes and turning into quicksand. I now believe that I used the frame of Shirley’s therapy as a crutch in my dissolving world. I felt that the frame had to be held on to at all costs, even if it did not “fit the picture” anymore.6

In any psychotherapy or psychoanalysis, the needs of the therapist and those of the patient are not perfectly aligned. Quite often the therapist must bend his subjectivity to meet the patient’s self needs, but there are also times when the therapist’s and patient’s needs collide more forcefully, at which point it becomes the role of the therapeutic process to negotiate and balance these different needs. In this respect, I am in agreement with S. Stern’s (2004) view. At times of war, and especially with highly traumatized patients such as Shirley, the increased external tension and anxiety can bring the needs of the patient and therapist to a head-on collision. This represents a critical dilemma for the therapeutic process in times of war. On one hand, the emotional needs of the patient may be greater and more acute than before the war. Yet on the other hand, the therapist’s time and psychic energy might be consumed by his own war-related fears and needs. This was the case in my experience with Shirley. My needs and my family’s needs demanded that I take care of them and leave Shirley on her own, while Shirley’s self needs demanded that I stay with her, as there was otherwise a risk that she would experience a retraumatization. These diametrically opposed needs put me in a very difficult position and caused me great distress. I felt very concerned for Shirley’s mental state, and I was very ashamed of my narcissistic needs, which demanded that I be able to adhere to my professional standards no matter what obstacles appeared. My feelings at the time—which I later identified to be a manifestation of my ideal omnipotent self—caused me to experience a paralysis. In one of his most brilliant contributions, Kohut (1972) addressed these issues, saying, “Underlying all these emotional states … is the uncompromising insistence on the perfection of the idealized self object and on the limitless power and knowledge of the grandiose self” (p. 643). Bion (1975), too, addressed the issue of shame and mortification in most of his writing, particularly in his last work, A Memoir of the Future.

Perhaps the most important issue raised by the example of Shirley’s analysis is my lack of inner freedom at the time to entertain several courses of action (Symington, 1986), my inability to reflect on my alternatives and/or to share and negotiate them with Shirley, as if the undigested shame and fear had “murdered my mind” (a la Bion). The “simple” question of whether therapy under such conditions can and should be continued was never raised. We think that the question was neither formulated nor discussed because Shirley and I were caught in an “either/or” situation.7 There were two possible alternatives which I could only think of afterwards: the first option was to ask a couple who lived in my office building (both of whom were social workers) to allow Shirley to join them in their protected home while the sirens went off. The

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second alternative was that I would take Shirley home with me (taking into consideration all the complications such an alternative would create). There was no option of “standing between the spaces,” to quote Bromberg (1996). This would have required, first, containment of fear and shame, and second, acceptance of limitations and imperfections in oneself. The therapist has to come to terms with his sometime helplessness and with his limited ability to protect the patient and maintain the therapy setting as a reliable container. The fact that I could not maintain the therapy setting was a painful and shameful realization. My ideal omnipotent self could not accept this fact without bitter resentment and struggle, demonstrating one of the major strategies of the ideal omnipotent self: to turn a blind eye to a challenging situation in order to hide and cover it up.8

Both Shirley’s and my behavior thus contributed to an impasse in the therapy. My inability to confront my limitations paralleled Shirley’s inability to confront her terror at the prospect of re-desertion. Shirley and I, out of fear and shame of admitting our shame and fear,9 had dissociated our fearful and shameful selves from other parts of our selves. Only when we dissolved this shared illusion of omnipotence could we allow ourselves to own up to our fear and shame and resume the healing components of the therapeutic process.


The second example, which took place in 2006 during the Second Lebanon War, is taken from the analysis of a young man named Ron. Ron is bright, with a Ph.D. in natural sciences, and has been with me in analysis, five times a week, for the last 3 years. Ron is a difficult-to-reach patient. During one session, 2 weeks into the war, Ron came into the room looking happy and exhilarated, saying he wanted to go to Haifa and Kiryat Shmona (in the north of Israel) to roam the streets, as the experience seemed fascinating to him, and he could not understand why people were frightened and sitting in shelters. I felt that Ron was treating the bombs being dropped on those northern settlements with oblivious joy and was excited about the opportunity to relish the experience.10 It was clear that worry and fear were not a part of Ron’s immediate experience. Was he not afraid? Or was he too afraid, and unable to bear and admit it? Indeed, when I asked Ron whether he was not slightly afraid, Ron answered with euphoric arrogance: “Why? What is there to fear? Don’t tell me that you are afraid.”

Ron expressed an attitude of elation and overconfidence, denying the dangers of the war and disregarding the risks faced by people he knew who either were living in the north of Israel, where

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8”... the wish to wipe out the unbearable sense of mortification and nameless shame imposed by the ultimate recognition of a failure of all-encompassing magnitude” (Kohut, 1977, p. 241).

9Aristotle in the Nicomachean Ethics says, “Shame is the mental picture of disgrace in which we shrink from the disgrace itself and both from its consequences.”

10When I shared this paper with Ron, he wrote a few comments, and some of them were surprising to me. I thought I would pass some of them on to the reader—Regarding the issue at hand: Ron wrote, “My mother recalls from the first day of the Lebanon War, when we were living in the North, I was six and my brother was four, I woke up from the sounds of the bombing, took my brother out, and we roamed the streets alone during the early hours of the morning. I have no recollection on this.” Interestingly enough, this was never brought up in our sessions, and Ron has never told me this story.
people were under missile attack, or serving as soldiers in Lebanon. His desire to go to the north showed complete disregard for the fact that he might be endangering himself with such a trip and similar disregard for his family’s potential feelings about such a decision.

The sessions just discussed were held during the first 2 weeks of the war. During that period, I was living in Tel Aviv and was not exposed to immediate danger, although there was a looming threat that Lebanon might increase the range of the missiles, enabling them to reach Tel Aviv as well. My daughter’s fiancé was a soldier in combat, performing a dangerous role in Lebanon. My daughter, who was in a sensitive emotional state, had returned to our home, and her worries and anxieties were a living presence in my mind. Ron’s blank emotional reactions and vain behavior, in the context of my emotional circumstances, created a complex and intense transference and countertransference configuration.

All of my attempts to get in touch with other self-parts of Ron with which I could empathize did not bear any fruits. I found myself annoyed, angry, and alone in my fear and worries. I felt we had reached a dead end: Ron was deeply entrenched in his dissociation from fear and the grim realities of the war, and therefore, I thought, I could not reach him. There arose in me feelings of helplessness and incompetence, as well as piercing questions regarding how one helps individuals who lack an ability to contain fear and feel ashamed, or, put differently, an ability to bear feelings that are causing psychic pain.

In one of those frustrating sessions with Ron, I found myself having flashbacks, which gradually developed into memories, of some awful events from the Yom Kippur War. These flashbacks and memories have come to haunt me from time to time over the past 30 years or so. At times, I can see pictures of dead bodies and injured soldiers, like in a silent movie, while at other times I see the same visions but accompanied by sound. I remember the rain of bullets and bombs around us, the corpses, and, most horrifyingly, the shouting of the wounded soldiers for whom we could do nothing to help. Over the years, I have come to learn that I cannot really forget or eliminate these pictures of horror, and every time the memories fade away I await their return as the return of a frightening and unwanted but familiar visitor.

In October 1973 the Yom Kippur War broke out in Israel. My wife and I were in New York at the time, working and preparing ourselves for enrollment in our doctoral studies. From the moment we learned of the outbreak of the war, and as the hours went by, a general feeling pervaded us that this was not “just another war” and that Israel was fighting for its very survival. The day the war began, my friend and I reported to the El Al desk at Kennedy Airport in New York at noon, and by the end of that night I was already a fully equipped and armed soldier, stationed in the Golan Heights in an armored infantry platoon of soldiers who had volunteered and come from abroad.

After 10 days of hard fighting in the Golan Heights and being wounded by shrapnel in one of my legs, which required 2 days of hospitalization and some stitches, I joined a platoon that went down to Sinai. One night, we crossed the Suez Canal and landed in a deadly ambush by an Egyptian commando unit positioned on a high dirt battery. My platoon lay about 20 meters below them with no hiding place. The Egyptian unit fired upon us continuously with machine guns. We were like sitting ducks. The ambush continued for a whole evening and night (from 7 p.m. until 5 the following morning). Of the platoon’s 50 or so soldiers, more than half the force was either killed or wounded.\(^{11}\)

\(^{11}\)Because of Michael’s very personal experience, the two case studies are presented in the first person.
During that war, and particularly during that bloody ambush, I learned one of the most important lessons of my life. The platoon I had joined was formed from soldiers of diverse backgrounds who did not know one another before. Amongst the soldiers there were two very “manly” fighters, from special units, who were overjoyed at the prospect of battle. I remember being impressed by and envious of their robust appearance. What aggravated and diminished my emotional balance further was that most of the time I was afraid and very ashamed of being afraid. I also feared being exposed as a coward. They, on the other hand, were really macho, strong, and full of self-assurance. But what happened to these two soldiers during the deadly ambush left me stunned; it was they, the super-manly soldiers, who could not face the helplessness and the fear of dying that was hovering over our heads. One of these two soldiers rose up in the middle of battle and started to flee, a seemingly suicidal act, given that we were under murderous fire, and indeed he was shot and killed immediately. The other fighter entered a state of shock and started foaming at the mouth. With the combined efforts of several soldiers, we took care of him and managed to save him from strangulation and certain death. For many months I was preoccupied by an attempt to understand what had actually happened there, which seemed to me at the time to be an insolvable paradox. During the attack, I and several soldiers lying near me were in a state of extreme fear, yet we continued to function on automatic pilot. The “manly” soldiers, on the other hand, who had never acknowledged any fear, broke down in ways that proved life threatening.

While totally absorbed in these memories and thoughts, I suddenly and vaguely heard Ron’s voice, challenging me, “Don’t tell me you’re scared.” I answered that I felt some fear, and that I was concerned. I did not want to expose the significant gap between his emotional stance and mine, and hence I refrained from admitting the full extent of my fear, as this would have drawn him further from his feeling of fear. Ron’s blatant disregard for my feelings continued as he told me that he did not believe me, that this must be a therapeutic manipulation, and that “just as I thought, you are not really scared.”

This saddened me and I felt dull, devoid of ambition to help Ron reach the point at which he would be able to feel connected to other parts of himself, including a part that could contain fear. Later on I was able to realize that by blocking off his own thinking, Ron was fending off the violence he would have encountered if he had allowed himself to face reality. To some extent, I was more preoccupied with my own fears, shame and agony, remembering my experiences in the Yom Kippur war.

After a while, I found myself thinking about the extreme contrast between his “lack” of fear in the present situation and a psychotic panic he had experienced 2 years prior. At that time, Ron had telephoned me (this was the first and only time he has done so throughout the years of the analysis) in panic, saying that the girl he had been dating “attacked” him and tried to kiss him. He said he felt as though a monster from another world was going to devour him. Two days following that event, he turned to me in the session and said that my mouth stank, and that if I did not take care of it, he could no longer stay in analysis (there seems to be no need to elaborate on the level of psychotic fears that both mouths were threatening to devour him).

My personal memories from the Yom Kippur War, along with memories of the psychotic fears of my analysand and his limited capacity to contain any intervention expressing an understanding even slightly different from his, caused me to tell him, in a hesitating tone, that we all need to learn to be able to be afraid. I added that the conditions suitable for this discovery had yet to form in his

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12For further elaboration, see Shoshani (2010).
life. I said that I understood his feelings, as we all find it very frightening to be afraid. He replied, “You’ve started to confuse me again. All my life I have learnt how not to be afraid, and here you come and turn things upside down, telling me that I need to learn to be able to be afraid, as if being able to be afraid is a strength.” I told him I knew that most of his life, especially since the traumatic and shameful events he had experienced in kindergarten and elementary school (both of us knew to what I was referring), he had tried very hard to suppress his fears, and that therefore my advice was confusing. I then asked Ron to consider which party was “more afraid,” a person who exhibits fear when facing extreme danger or one who does not exhibit fear while facing extreme danger. Ron said, “What do you mean? The answer is crystal clear.” I replied that there is often “more than meets the eye.” Ron was silent, and seemed to contemplate this notion. I thought that although my statements seemed perplexing for him, they had struck a chord, and perhaps Ron was able to see some truth in them.

What was perhaps even more important took place in the following session, 2 days later. In that later session, Ron said that he was thinking once more, as he had many times before, about the issue of fear. Although he was still not able to connect emotionally to what I had said, it now made sense to him cognitively. Ron stated that he believed it was true that people who can tolerate and be in touch with their fear are probably stronger than those who cannot experience and bear it. Ron added, in a nonconfrontational manner, “Michael, I want to ask you something: why is it so important for you that I admit that I am afraid?” Frequently, in analysis, the best guidance one can receive is from the patient. I am reminded here of Bion’s wisdom: “In short, the most important assistance that a psychoanalyst is ever likely to get is not from his analyst, or supervisor, or teacher, or the books that he can read, but from his patient. The patient—and only the patient—knows what it feels like to be him or her” (Bion, 2005, p. 3).

I remember I felt exposed and ashamed, yet also relieved. I felt that Ron had removed an intrapsychic—as well as an interpersonal—blockage. I had some hesitations as to whether to share with Ron the essence of my traumatic experience during the Yom Kippur War and my concerns regarding a family member who was fighting in Lebanon at the time. Eventually, I decided to share this information with him. I briefly told him of my experiences during the Yom Kippur War, without sharing my conclusions about my experience, which I discuss shortly. I also told him that a member of my extended family was currently fighting in Lebanon. I admitted that his question had a ring of truth for me and that I had not been aware of pushing him to admit he was afraid until he voiced his question. I added that I thought the two events I had shared with him had affected me in ways I was not aware and had caused me to try to induce him to confess his fears. Ron was very excited and grateful for my sharing with him my memories and my current concerns. He said that he did not recall in the 3 years we had been working together such a disclosure on my part and that I was probably going through a rough time.

In response, I asked Ron what his thoughts were regarding my insistence that he admit he was afraid, now that I had shared with him two intimate thoughts. Often, I ask my analysands to try to

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13Ron was rejected and boycotted aggressively by all of his classmates, and by all of the other schoolchildren, because he urinated in his pants and would pick his nose and eat the “boogers,” along with other disgusting habits.

14Ron’s second comment on this paper was the following: “I think you should include the metaphor that you used in that specific session when we discussed the issue at hand. I remember that you said that I should try to compare a solid, unbendable road to a road made of steel, but capable of bending. I remember it very vividly because it hit home for me back then, and it still does.”
understand and explain unexpected and surprising statements or behaviors of mine. Over the years I have concluded that this practice aids and enriches my understanding of my own inner workings (countertransference in the broad sense of the term), as well as the relationship between myself and my patients. It also contributes significantly to the feeling that analyst and analysand are a team working together, decreasing the feeling of asymmetry and increasing mutuality. I am not the only one who can see and interpret; the patient can also see and interpret. In this regard, Ron said many interesting things, on which I do not further elaborate here.

Later that night, I had what to me was a very interesting insight. I asked myself whether it was possible that I had unconsciously orchestrated the whole scene wherein I would have to tell Ron my memories of the Yom Kippur War, as well as my present worries, because I needed the acknowledgement of the traumatic events I had experienced and of my current fears. It reminded me of a woman patient of mine who was raising an autistic child, then 7 years old. She often expressed her agony and desperate need to hear from her autistic daughter the word “Mommy,” which she had never heard. Perhaps, in a similar vain, I needed my patient’s recognition of the horrors I had experienced and the fear I was experiencing at that time. I was of two minds: on one hand, it seemed that I needed this recognition for myself as a person, and on the other hand, it seemed that I needed this recognition as an analyst. Like my woman patient who needed to be acknowledged as a mother, I needed the acknowledgement of these fragile parts in me in order to be able to summon my stronger self-parts as an analyst. However, I also considered the possibility that what I had experienced was a countertransferential reaction that should have been taken care of, understood and resolved by myself (possibly with my analyst) without allowing it to interfere in the psychoanalytic process. This very important issue of our need for recognition as human beings and as therapists has many implications. In line with this, we should also pay attention to the patient’s needs at different stages of the analysis. In other words, we as therapists should consider at any given moment what the patient can bear knowing about the therapist, what the patient needs to know, and what the patient should not know. Similarly, attention should be paid to what the therapist needs the patient to know and what the therapist needs the patient not to know.

I felt that Ron and I were able to move closer to allowing him to experience fear, even if only by a few inches. Our achievement related to my being able to reconnect to the experiences of the Yom Kippur War, to re-experience the envy towards the two seemingly fearless men, to be in touch with a terrible fear of dying, to relive the shame of the betrayal of my body at the time of the ambush and to hold on to my current fears for my future son-in-law fighting in Lebanon. Empathizing with these fragile parts of myself, and sharing them with Ron, I became aware that Ron really needed his manic and dissociative defenses in order not to collapse, in a manner similar to the two soldiers in the Yom Kippur War. This understanding enhanced my ability to change my emotional attitude toward Ron. To put it in different words: I believe that my self-analysis has helped me to empathize with Ron’s defenses against experiencing fear. The more I was able to accept my fears, the more I was able to accept his inability to experience fear.

In complete agreement with Bollas (1979) and S. Stern (1994), I believe that the transformation begins within the analyst as he aims to create a distance from the emotional countertransference. The analyst remembers the traumatized child within himself and then the traumatized child within the patient, whose developmental and relational needs have been thwarted and for whom the relationship with the analyst is yet one more version of re-experiencing his past trauma. This perspective enables the analyst to gradually shift towards a new affective response. This affective shift within the analyst ends the vicious cycle and signals the analyst’s availability as a new object, to
paraphrase S. Stern (1994). I believe that Mitchell (1988) was referring to similar issues in the following paragraph.

The analyst discovers himself a coactor in a passionate drama. … The struggle is toward a new way of being with the analysand. … The struggle is to find an authentic voice in which to speak to the analysand, a voice more fully one’s own, less shaped by the configurations and limited options of the analysand’s relational matrix, and, in so doing, offering the analysand a chance to broaden and expand that matrix. (p. 295)

The transformation of my relationship with Ron, resulting from the removal of the blockage, had opened a path within Ron. But more importantly, it had opened a path within me that allowed me to more fully reconnect with Ron’s traumatic childhood experiences that shaped his incapacity to contain fear and shame. In his youth, Ron’s father had adored him, calling him “my precious.” But then, suddenly and without explanation, he rejected him and dropped him emotionally at the age of 6, for reasons that were not understood. This sudden and unexplained falling from grace left Ron with a basic feeling of inadequacy and awful shame. His mother, instead of responding to Ron’s needs, made him accommodate to her “own gestures” (Winnicott, 1965). This is the scenario to which Winnicott refers as the “not good-enough-mother,” where there is no giving from the mother to the child, forcing the child to adapt itself to the mother rather than the other way around. In behaving thus, I believe Ron’s mother obliterated his personal nature. Ron has been left with a false self. This personality organization has been crystallized in such a way as not to allow him to be in touch with fear or shame, as these feelings may endanger the very foundation of his extremely fragile psychic structure.

Following my emotional shift, I was more inclined to share the shame inflicted on him by his grandiose self. I thus helped him to contain and share the burden of fear and shame, as two men who dared to be human. The more Ron could experience his imperfection and frailty while being supported by me, the more he could, gradually, let go of his defenses. Ron has completed a significant part of his journey, as demonstrated by his ability to partially give up on the omnipotent position, though the process was and is still far from over (I am not sure whether any of us will ever complete this journey). Only recently, almost a year later, Ron and I have started to discuss openly his fears during the Second Lebanon War, which is a significant accomplishment.

REFLECTIONS, QUESTIONS AND DILEMMAS

It is the weakness of the human being that makes us sociable; it is our common miseries that turn our hearts to humanity; we would owe humanity nothing if we were not human. Every attachment is a sign of insufficiency. If each of us had no need of others, he would hardly think of uniting himself with them. Thus from our weakness our fragile happiness is born. (Rousseau, Emile, Book IV)

As we decided to focus our presentation and discussion at the clinical level, questions regarding the differences between trauma, shock, anxiety, and fear have not been addressed. These are important theoretical issues. However, we thought that dealing with them would have taken us

15Another comment in Ron’s letter to me: “‘The more Ron could experience his imperfection …’ I think that is wrong. I think the more I could experience your humanity and imperfections, the better I could take a look at my own.”

16I am grateful to Benjamin Kilborne, Ph.D., for introducing me to this moving quotation in his article “The Importance of Shame in Clinical Work” (Kilborne, 2007).
away from the clinical-phenomenological level. Having said that, we here try to develop some ideas about fear and its vicissitudes and transformations in the therapeutic setting.

As previously described, Ron’s analysis took Michael back to the traumatic events of the Yom Kippur War. It took many months for Michael to realize that the ability of the soldiers in his unit to bear their fear was the very thing that kept them from entering a state of shock, which, under those particular circumstances, would have had deadly consequences. One can argue that the ability to bear and to feel fear was what kept the other soldiers sane. The two soldiers who were unable to be afraid collapsed during the most trying moments. Years after the war, Michael arrived at the understanding that in most cases, people who have the capacity to be afraid actually fear less than people who seemingly “aren’t afraid at all.” Feelings of frustration, anxiety, guilt, shame, fear, and helplessness are among the most difficult of all emotions to contain. The question that Michael had struggled with was the “dosage of fear” one should be able to tolerate and contain so that on one hand, it will not paralyze and immobilize him, and on the other hand, it would not cause the person complete and massive denial of the fear resulting in a mental collapse during a severely trying time. One could say that there is a negotiation going on internally between the denial of fear and the overcoming of fear. To put it in other words, there seems to be dialectic relationships between fear which is owned by “me” and fear that is disowned and is transferred outside to the “not me.” There is supposed to be some elasticity between the “me” and the “not me” so that as the schism between them will not be too extreme. People will go to extraordinary lengths, distorting reality and bending perception, in order to avoid coming into contact with these feelings. People who cannot endure psychic pain end up suffering the most, just as the two seemingly fearless soldiers suffered as a result of their inability to get in touch with and bear their psychic pains: the emotions of fear, shame, and helplessness.

We are convinced that there is a strong link between a person’s capacity to bear and contain psychic pain (e.g., helplessness, anxiety, guilt, shame, and fear) and that person’s mental health and ability to truly live, not merely survive. In our opinion, two of the primary functions of a therapist are, first, to allow the patient to experience increasing dosages of psychic pain without diminishing the “floor” of his mental existence (in order to prevent, as Winnicott, 1974, and Kohut, 1984, emphasized, retraumatization), and second, to repair his psyche’s “shock absorbers” in order to prevent them from fracturing their mental spinal cord over life’s bumpy roads. One of Mi-

\[\text{SHOSHANI, SHOSHANI, SHINAR}\]

17We, the authors, made the decision that as long as we were “in” the clinical examples that were taken from Michael’s practice that we would refer to Michael in the first person. We are now changing the perspective to the third person since we are no longer “in the sessions” but discussing them and these discussions represent the opinions of all three authors.

18Here are some of Grotstein’s illuminating remarks on the earlier version of this paper during the war itself. The remarks have to do with fear and defenses against feeling fear: “Bion talks about those who cannot suffer pain must endure it (namelessly as beta-elements). I think that is what you are talking about. Your patient was in a state of negative K (-K). You were absolutely right in asserting that we must be able to accept experience and acknowledge our weaknesses in order for our strengths to be effectively summoned. The two men you talked about in your platoon which was ambushed, are prime examples of what Klein calls the ‘manic defense.’ A triumph, an imaginary, omnipotent fantasy in which they show triumph contempt and control over the objects they depend on, and also over the depended infant who depends on this object. I think you’re right about the concept of ‘unfelt experienced’ … From one standpoint, psychoanalysis has as it’s main purpose to complete those experiences we’ve had that were left uncompleted because we didn’t feel strong enough or our objects didn’t feel strong enough to contain us. Bion first came up with concept of container/contained—then alpha function—and then dreaming. We suffer from unsuccessful dreaming. Every event must be dreamed in order to become normally unconscious or to be able to become conscious as well. If we cannot dream the event becomes a beta-element that nags at us from a psychic retreat or pathological organization” (J. Grotstein, personal communication, 2006).
Michael’s patients, a man named Carl, had, at the age of 10, suffered from cancer and for several years was at risk of dying. During therapy as an adult, Carl referred to several years of his illness as “silent movies, without emotional captions.” Shoshani and Shoshani (2003) called this phenomenon the “unfelt experienced.” Donnel B. Stern (1997) provided a lucid explanation of the same phenomenon, for which he coined the term the “unformulated experience.” The only way a patient can unfreeze these parts in himself is through the presence of a transformative object, ready to share the load of the intolerable emotional pain. During therapy, Michael suffered with the cancer-ailing child that Carl was. Michael was scared with him and cried with him. Michael shared the shame of being defective and the insult of being a deviant, as both Carl and Michael passed through this private disaster together. Carl experienced this disaster for the second time during therapy but lived it for the first time. Some pains in life can be better endured by two hearts, especially during times of crisis, when the mental “digestive system” of a child or an undeveloped psyche cannot metabolize such pains. Michael was the thinker and the bearer of the thoughts and feelings Carl could not bear, until such time that he could contain the traumatic event he had experienced, thus regaining his mind and becoming himself the thinker (a la Bion).

Returning to Michael’s memories of the Yom Kippur War, using Winnicott’s (1974) concept of “fear of breakdown,” we might guess that both of the seemingly fearless soldiers were in fact protecting themselves by using manic defenses and dissociation processes to avoid reliving a terrible calamity that had already happened in their past, one that was never metabolized, digested, and owned by their psyches. These two soldiers, like Ron, exhibited behaviors and attitudes that, as Bion would put it, showed signs of an “early psychological disaster.” We believe that, in extreme emergencies that are life threatening, an ontology that assumes the aim of the psyche to be psychic survival provides a comprehensive explanation of one’s mental and emotional states. It should be noted that although we use the term “psychic survival,” we do not in any way refer to an instinctual force; we refer to a crumbling and suffering self that is the thrust behind the terror of retraumatization. This ontology captures the complexity of one’s mental and emotional state (Shoshani, Shoshani, & Becker, 2006). People will go to great lengths in order to protect their psychic survival; paradoxical as it may sound, they are willing to sacrifice their corporeal survival in order not to re-experience the calamity of a psychic breakdown that has already happened but has yet to be lived through. So as to illustrate this, we might imagine that this fit the behavior of the first soldier who stood up in the middle of the ambush, a suicidal act serving to terminate the agony of the potential first reoccurrence of the psychic calamity.

Regarding issues of therapeutic technique, we believe that the first and foremost task of the therapist is to look into himself, sometimes into the depths of his own psychic abyss, in order to find a psychic tissue similar to the one to which the patient is referring. Only when Michael, as Shirley and Ron’s therapist, was able to reconnect with these parts within his psyche was he able to reconnect to his patients. Interpretations are not intellectual constructions; they should come from a compassionate element within us. Yet even this may not be enough. Interpretations should allow the patient to feel and recognize that the therapist not only knows what she is talking about but also has experienced similar painful emotions by searching into the darkest part of her soul. In each of these therapies, it was the patient’s questions that removed the deadlock in the therapeutic process. It is our contention that patients, as well as children, very often tell us in multiple ways (verbally and nonverbally) what they need so that the impasse can be removed. It is we therapists (as well as parents) who are quite often hard of hearing. We are very lucky that both children and patients are very patient with us; they repeat their requests
time and again, until we are able to listen and hear them. This is another way of saying that a transformation starts within the analyst.

This idea is expressed profoundly in the following story. As the story goes, the grandfather of the last Lubavitcher Rabbi, himself a great rabbi in Czarist Russia, used to listen to his petitioners individually at his house. One morning, the Rabbi’s door remained closed for half an hour or more, and the silence seemed peculiar and worrisome, creating much anxiety among the many who were gathered in the Rabbi’s study, and soon throughout the village.

Trembling, and with great hesitation, Reb Pinchas, the Rabbi’s assistant, put his ear to the door and heard the Rabbi’s voice. He was weeping. After a few moments, the assistant dared to nudge the door open. He asked the Rabbi what had happened, and could he help? The Rabbi leapt to his feet and exclaimed, “Make haste! Gather all the Hassidim into the synagogue! Let it be known that I will deliver a derashah, a sermon.” He then said, “Do you all know how it is that I am able to listen to your problems and troubles, how it is that I am able to help at all, and understand? It is because I look into my soul and can always find some inner ‘garment’ that is similar to what you are telling me. This morning one Hassid confided in me something very dark, very terrible, and very painful. And as hard as I tried to search my inner self, I could not find anything that was in any way similar to what he was telling me. Now, you might think that this proves I am on a higher level, that I am untainted in certain ways by certain base instincts and desires. But I tell you that is exactly why I was in despair! Because I am sure that such an impulse and forbidden desire exists in me as well, as it does in everyone, but I have no mastery over it—I cannot ‘see’ it—and that is worse than the forbidden desire itself. Because without this knowledge and feeling, I cannot empathize with the person I am speaking to.”

With both Ron and Shirley, Michael used self-disclosure, which he does not do very often. In retrospect, Michael has noticed that, although unaware of it at the time, he tends to use self-disclosure with patients who are difficult to reach, who he believes have a “Basic Fault,” to use Michael Balint’s terminology. With these patients Michael believes that his empathic failures are not and cannot be received by the patients as minor failures; most of them have the impact of inflicting a trauma on the patient. This was true for both Ron and Shirley, who, as previously discussed, were badly traumatized in their childhood. In both instances Michael considered himself to be a coactor in the emotional drama played out in the therapy room. As such, he considered it appropriate to share the responsibility of what was happening in the transference–countertransference configuration. Tentatively we would like to suggest that the more similar the therapist’s wounds and traumas are to the patient’s, and as long as the therapist has worked through them, the greater the likelihood of the therapist being able to connect and help the patient, whether it be through self-disclosure or just through empathy without self-disclosure but still based on similarities of their emotional histories. We are not sure that we are offering a different conceptualization than the one known under the heading of “the wounded healer;” but as we have tried to show through the story of the rabbi, we see it as a very significant dimension in the psychotherapeutic endeavor.

This might be a good place to state our attitude towards self-disclosure. We do not object to or advocate self-disclosure as a therapeutic technique, but we do not recommend it as a rule of thumb either way. It is a double-edged sword. At times the sharing can be very helpful and enhance the

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19We are grateful to Moshe Halevi Spero for introducing me to this beautiful and illuminating story.

20Grotstein (personal communication, 2007) commented that this story a marvelous exemplification of Bion’s concept of Transformation in O.
healing process, while at other times it can overburden and even severely traumatize patients. Overall, we would say the decision to use this technique should take place on a case-by-case basis. One more substantial reason towards Michael’s decision to use the technique of self-disclosure is to display to the patients how his mind works, which we strongly believe enhances the process of their mentalization. In this instance with Ron, it happened to be an important and successful tool in this respect. Ron told Michael that he finally understood his relentless insistence that he confess his fears. On the other hand, as Michael has already mentioned, at times it can be a burden on the patient, one that is not his to carry. For instance, Ron apologized saying it had not crossed his mind that some member of Michael’s family might be involved in the war, and he felt poorly for not having entertained such a possibility. The feelings of guilt that arose in this case were inappropriate; it was as if Michael had condemned him for not “seeing me.”

Generally, analysts must be “sick” enough to be able to understand their patients’ deepest and darkest abysses, and “open” enough to be able to find within themselves an echo of their patients’ most horrifying and remote psychic experiences. Nevertheless, analysts should also be healthy enough to be able to pull their patients out of their misery. This may allow analysts to transform themselves into “detoxifying agents” and consequently aid their patients in retrieving parts of their selves that were disowned as a result of their psychic inability to process and digest their traumatic experiences, memories, and feelings. This detoxification process should be done with compassion, in order to provide resonance to the patient’s most painful experiences of shame, helplessness, and fear.

Michael believes that in Shirley’s case, his inability to accept his limitations and his attempt to cover up these imperfections increased the very same emotions of shame and fear that he could not contain at the time and had attempted to conceal. In a similar vein, in the analysis of Ron he was flooded with the emotions of fear and shame of which he was not completely aware as a consequence of his traumatic experience in the Yom Kippur War and because of his worries about his family member who was fighting in Lebanon. As a result, both Shirley and Ron became very angry with him; Shirley expressed it directly and Ron expressed it through his contempt and condescension. Both Shirley’s and Ron’s rage, in our understanding, was a result of narcissistic fragility and vulnerability.

Based on our experience, we believe shame and fear to be emotions that liquefy and dissolve (see Symington, 2006) the self and make the person feel as if the floor is moving under his feet, whereas the emotions of anger and rage have a solidifying and “gluing” impact on the self. Anger solidifies the self and rage solidifies the experience of the self—of being alive. Our experience suggests that people like Ron and Shirley, who have been severely traumatized, are walking as though they have no “floor” under their feet and no beacon to direct them to safe harbor. These are people who feel that they have been exposed to a terrible injustice in their life. All these feelings, we believe, are transformed into a terrible narcissistic rage against the whole world. Many people would rather be in a state of rage than in a state of fear or shame, and we believe we can identify the move of the psyche from shame and fear towards rage as a strategy of buttressing the crumbling self. This conceptualization is based on the understanding that fear, shame and rage have an affinity between them. They are located in close proximity in one’s experience and are interwoven (see Kohut, 1972; see also Bion’s theory on groups in regard to three basic assumptions).

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21See Fonagy & Target’s (2007) *A Theory of External Reality Rooted in Intersubjectivity*.
22Symington (2006) and Alvarez (1992) expressed similar ideas in their writing.
We would like to examine these intrapsychic dynamics from an intersubjective point of view. Is it possible that as a result of Michael’s inability to contain his shame while working with Shirley, Shirley’s outrage at being rejected was a distorted and disguised expression of Michael’s own shame? And in a similar vein, in the case of Ron, is it possible that Ron’s contempt was a disguised distortion of Michael’s inability to contain his own fear. One more plausible manifestation of the intrapsychic dynamics from an intersubjective perspective regards Ron’s contempt as a displacement of Michael’s own contempt towards Ron usage of the manic defenses. Michael was unaware that the dynamic between him and Ron has echoed and replayed his retrospect contemptuous feelings towards the soldiers in the Yom Kippur War, deferred feelings that have gradually developed over the years, from an initial, naive, admiration to the recognition that their desperate actions stemmed in fact from manic defenses. These feelings have metamorphosed into the development of Michael’s negative attitude towards the patient.

In other words, we are suggesting a tentative formulation wherein these emotions not only constitute a single psychic fabric intrapsychically, but in fact can be enacted and played off of by different people, that is, patients and therapists as two organs of one psychic entity. It is a familiar experience for an analyst to feel ashamed and embarrassed when working with a patient’s perversions, even though the analyst cannot sense shame within the patient’s psyche. As we understand it, the analyst’s feeling of shame and embarrassment is an amalgamation of the patient’s unfelt shame and the analyst’s own shame regarding his own similar perverse fantasies. In such circumstances, we would argue, the analyst is playing off the shame that the patient cannot contain. It was Freud who taught us that one does not project onto clouds. Indeed, our core understanding of the process we have tried to illuminate is captured by the concept of “mutual projective identification.” Another concept which might capture the relationship between two different and separate individuals on one hand (e.g., patient and analyst) is also the one entity that weaves the two into one mental fabric results in the merger of oneness; isn’t it the relationship Kohuts tries to express in his concept of the self-selfobject?

Perhaps this relates to our experience that teaches us that shame and fear are often more difficult to own than guilt. As Fernando Pessoa (1998) wrote,

*Confessing not to sins but to infamies,*  
*Speaking not of violent but of cowardly acts!*

### SOCIAL DEFENSE MECHANISMS AND THERAPIST–PATIENT RELATIONS

A discussion of therapist–patient relations during times of war will not be complete without a brief discussion of the social sphere in which the therapy takes place. Both therapist and patient are, in most cases, members of the same society and influenced by the same social narrative. Following the work of Neil Altman (2005), who offered a view of collective defensive mechanisms as social patterns that are aimed at avoiding guilt and shame, we argue that the defenses employed by a society struggling to contain its fear create conditions that influence all members of that society. We believe that both therapist and patient are influenced not only by intrapsychic and interpersonal constellations but also by social mechanisms that shape their ability to contain and admit to their

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23We thank our editor, Stephen Seligman, for his insightful comments which pointed us in this direction.
own fear; the affinity between the reactions of denial of fear found in Shirley’s and Ron’s as well as Michael’s responses to the stressful circumstance hint at the manner in which the social defense mechanisms influence the therapeutic relations. Social defense mechanisms are setting the unspoken ground rules for how the external circumstances will be negotiated by both therapist and patient. They create a joint yet hidden narrative or ethos, which creates a united response to the repressed and undesired emotions felt by many if not most members of society with regard to the distressing external realities.

Fear occupies a significant place in the Israeli narrative, connecting the present violent conflict with the Palestinians with the traumatic past of the Jewish people—the Holocaust and centuries of persecutions (Bar-Tal, 2005). During its involvement in the intractable conflict with the Palestinians, Israeli society has developed specific social patterns to negotiate and cope with the prolonged exposure to violence that influences every member of the society. The collective response to fear is manifested by over-alertness, which in itself is a major cause of violence as well as of a reduction in the rational capacities of the given society (Bar-Tal, 2001, 2005).

The Israeli society is a society struggling to contain its own fear. On an individual level, the need to dispose of any sign of fear can have catastrophic consequences, as demonstrated by Michael’s memories of the Yom Kippur War. While a milder version of dissociation is also evident in the initial responses of Shirley and Michael to the threat of the missile attack, the manic position of complete denial of fear is more akin to Ron’s emotional stance. Ron tries to convince his therapist that both of them are not afraid: Ron’s use of seduction and flattery (Shoshani, Shoshani, & Becker, 2009) is an attempt to secure his counterpart’s (Michael’s) emotional participation in his manic position. In much the same manner, the Israeli public attempts to secure its own manic position by similar emotional archaic processes, for example, by attempting to publicly disown fear. Both attempts can be perceived as examples of a Faustian pact described by Rosenfeld (1964) in which those who wish to join the omnipotent position are required to relinquish their ability to remain in touch with their inner world and the emotions that make them human. As a result, the inner world narrows, gradually limiting the ability to think and feel freely. In other words, those who employ manic defenses are trading their “souls” for a false and temporary feeling of safety and security, freeing them from the terror of being afraid but enslaving them to the false and imprisoning god of omnipotence.

The trauma of the Holocaust is called upon to solidify existing fears and anxieties. Each threat to Israel, however trivial, quickly becomes a threat to Jewish survival (Weinberg & Nuttman-Shwartz, 2006). This is reminiscent of Bion’s saying that the war of the Marathon that occurred 2,500 years ago is still reverberating and still very much with us. Therefore, there is little wonder that the Holocaust is experienced not only as a trauma in Israel’s collective past but as part of its everlasting present. In such a present, Auschwitz is a “constant option” (Zertal, 2005), a real threat to Israel’s very existence that can materialize today, tomorrow—in an all-encompassing present time. This backdrop of a constant threat of annihilation colors every social and individual fear in Israel; thus every fear is potentially merged with the unmetabolized trauma. This is illustrated by the findings of a study on the dreams of Israelis in which Biran (2007) found that Israel is a society fearing annihilation, a society in which the prevailing fear is of an imminent reoccurrence of the Holocaust, a sense that is provoked each time fear of deportation arises. These observations regarding the role of the Holocaust in the current Israeli society echoes Dodi Goldman’s discussion of the manic defense, noting that such a defense is characterized by an inability to believe in one’s own liveliness, as it is based on a denial of inner deadness (Goldman, 2005).
Another way to think of Israeli society’s interplay between dissociation and awareness of fear is to use Winnicott’s concept of “fear of breakdown.” This concept was developed as an intra-psychic concept and was used in this article to discuss the mental breakdown of the two soldiers in the Yom Kippur War. Winnicott suggests that healing demands the patient to search for a detail of the past that has yet to be experienced, as “what is not yet experienced did nevertheless happen in the past” (Winnicott, 1974). In the context of Israeli society, we suspect that the trauma of the Holocaust has not yet been fully experienced, and therefore, the society fears a breakdown that will be as catastrophic as the Holocaust. On the other hand, we find it very difficult to judge whether or not the people have experienced and metabolized this catastrophe in its full effect or if this kind of trauma is something that can ever be metabolized at all. One thing we seem to be certain about is that the Holocaust has branded the collective memory of the Jewish People, leaving them in a mental state of such uncertainty that they live their lives as though their existence was hanging by a thread. At the present time, we are far from being able to comprehend the full ramifications of such a colossal catastrophe. Much has been written on this complex issue. Our present paper is unlikely to provide but a narrow perspective on it.

There are two tragic issues concerning the Israeli society’s fear of allowing its members to experience fear: one, people who are afraid are ostracized and stigmatized; and two, until recently, people who have been victims of trauma are not allowed to mourn their loss and have this loss publicly recognized.

As to the first issue mentioned, the work of Bar-On (1977) is a tragic but illuminating piece of evidence. During the early years of Israel as a young state, Bar-On noted, little room was made for expressions of fear. Israeli soldiers that fought in the War of Independence (the 1948 war), and consequently suffered from battle shock, were left to cope on their own with their psychic scars, and were labeled “cowards” (Bar-On, 1997). The Israeli people, who felt themselves to be fighting for Israel’s existence and felt threatened by imminent annihilation struck a Faustian pact. They received a fearless, robotlike manic army, and they paid in return with the elimination of humanness—any feelings or signs of fear, helplessness, anxiety, injustice, guilt, shame, and so on. Ron’s behavior is a case in point: his euphoric attitude and manic defenses have been erected in order to dissociate and disown his own feelings of frailty.

In regard to the second issue, we wish to briefly discuss the role of the victims in traumatized societies. Thomas (2006) argued that traumatized societies often refuse to allow their victims to achieve a registration of their suffering in the public sphere. Bar-On’s research provides a demonstrative example of Israeli society’s failure to allow such voices to be heard. This relates to the inability of Israeli society to work through the mourning of the survivors of the Holocaust (Weinberg & Nuttman-Shwartz, 2006). The difficulty of containing fear has created a society that struggles to deny public registration of its individual members’ fears. Although this process began in the early days of Israel, six decades ago, it can be argued that it has not ended and continues to influence the society as a whole and thus, the psychoanalytic treatment as well. Awareness of the often subtle nature in which social defense mechanisms influence the intrapsychic level as well as the interpersonal level in therapy is a challenge for all therapists.

24 In the context, see Vanik Volkan’s illuminating discussion of his concept of chosen trauma (Volkan, 2009).
25 In the last decade, although gradual, a significant change has started to occur. The Israeli society has started to enable and legitimize the working through of the mourning of the survivors of the Holocaust.
CONCLUSION

Fear, frustration, anxiety, guilt, shame, helplessness, and depression are seven of the deadliest emotions, difficult to contain and causing psychic pain (sometimes unbearable psychic pain), yet our psychic survival depends on our ability to bear them. Distance and dissociation from these difficult emotions paradoxically limits, constricts, and diminishes our humanity.

Societies that deny the right to experience painful emotions such as fear severely limit their members’ ability to curtail their own omnipotence, and thus their ability to acknowledge the existence of the Other. Therapists, as well as patients, as members of such a restrictive society, are not likely to acknowledge their roles in buttressing this problematic social alliance or recognize its significant place in the therapy.

In times when the world is becoming an increasingly risky place for us all, psychoanalysts are called upon to be mindful of their own attempts, as well as those of their patients and their societies, to distance themselves from fear, shame, and other painful emotions in an attempt to maintain an illusory therapeutic cocoon, as there will surely be a psychic toll paid for such coddling.

This paper discussed violent circumstances that many psychoanalysts will, we hope, never have to experience firsthand. Still, we believe that many of the dilemmas that face therapists during times of war are but extreme versions of questions that influence therapy in “normal” times. War strips away the illusion that the analyst possesses omnipotent therapeutic powers that can protect the patient, revealing a mere mortal therapist, a potentially leaky container, and a severely cracked therapeutic frame. We believe that further research should be undertaken in order to fully apply psychoanalytic concepts to societies in distress.

War frequently brings with it a crisis in therapy, at least an immediate one with regard to the setting, and such a crisis may cause a paralysis for the analyst/patient team. Yet crises also often provide opportunities for developmental leaps. A difficult situation forces the analyst and analysand to negotiate the frame of the analysis, as well as their loyalties and commitment to each other and to the psychoanalytic endeavor. These negotiations are an integral part of the analytic process itself. The result of such negotiations is a gradual diminishing of both the patient’s and analyst’s omnipotence and an enhanced opportunity for two interacting subjects. If these developmental achievements are successfully negotiated, both participants on this joint journey achieve a greater sense of agency as well as the ability “to put oneself as a thing among other things in the world,” as Piaget would have said it. This new ability leads to a healthier balance between “subjective self-awareness and objective self-awareness” (Bach, 2006), which is the soil in which a true mutual recognition and love can blossom and flourish.

REFERENCES

CONTRIBUTORS

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