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Beyond the Unthinkable: Patient and Therapist in a Shared Collective Trauma

Hinter dem Unglaublichen verbirgt sich das kollektive Trauma von Patient und Therapeut

Zusammenfassung Der Beitrag der israelischen Kollegin thematisiert die Schwierigkeiten psychotherapeutischer Arbeit unter den Bedingungen kollektiver Traumatisierung, die beide Partner der therapeutischen Dyade trifft, und der sie sich nicht entziehen können. Die Autorin geht von der Hypothese aus, dass die Identität der Psychotherapeutin in einem kulturellen Kontext geformt wird und von diesem nicht getrennt werden kann. Sie untersucht die Schwierigkeiten, denen sie als Psychotherapeutin unter den gegenwärtigen Lebensumständen in Israel begegnet: Wie können kollektive Phantasien und Erfahrungen, die sie mit den Patienten teilt, von den individuellen des Patienten und der Therapeutin unterschieden und bearbeitet werden?

Sie beginnt mit der Beschreibung der kulturellen Erfahrung israelischer TherapeutInnen: die individuelle Geschichte ist eng verknüpft mit der kollektiven Geschichte des Landes. Alle Israeli teilen eine enge Verbindung ihres Lebens mit der Armee. Die individuelle Bedrohung ist eng verknüpft mit der Bedrohung des Landes. Das Wissen, jederzeit selber Opfer einer Gewalttat werden zu können, ist eine kollektive gemeinsame Erfahrung und Bewusstheit.

Die kollektive Identität des jüdischen Volkes ist nicht nur sozioreligiös fundiert, sondern auch um gemeinsam erfahrene Traumata zentriert. Neben Ritualen des Erinnerns und Trauerns gibt es auch ein starkes Verlangen zu vergessen, und die Wirkung des Traumas zu verleugnen. So sind Verleugnen, Verwerfen und Flucht in die Normalität Anpassungsmechanismen im Alltags-

"I, may I rest in peace-I, who am still living
May I have peace in the rest of my life.
I want peace right now while I am still alive.
I don't want to wait like the pious man who wished for one leg
Of the golden chair of paradise, I want a four legged chair. Right here, a plain wooden chair. I want the rest of my peace now.
I have out my life in wars of every kind: battels without
And within, close combat, face to face, the faces are always
My own, my lover-face, my enemy face.
Wars with the old weapons-sticks
And stones,blunt axe, words,
Dull ripping knife, love and hate,
And wars with new fanged weapons-machine gun, missels,
Words, land mines exploding, love and hate.
Idon't want to fullfill my parents' prophecy that life is war.
I want peace with all my body and all my soul.
Rest me in peace".

Yehuda Amichai
Israeli poet (1923–2001)

Introduction

The earliest and some of the most creative developments in psychoanalysis took place in Europe at a time when the continent was devastated by the two most destructive wars in history. Yet, these developments related, almost exclusively, to the inner life of the individual. On the other hand, the analysis of collective violence cannot be reduced to a single dimension because it targets the body, the psyche, as well as the sociocultural order. Extreme violence attacks the internalized, culturally constituted webs of trust. In this context, the boundary between inner and outer reality is rudely blurred and so is the difference between the patient and the therapist.

While many books and articles have been written in the mental health field about traumatic stress situations, articles on the psychotherapist's role in such situations are still in their infancy. Thus, for example, Noy (2000), in his comprehensive volume rich with research and practical material on therapy in traumatic stress situations, devotes only one page to an item he calls "Dangers to the Therapist's Mental Health." These dangers, he writes, exist because therapists, in response to trauma, do not simply observe, they are involved in the process.

At the time when therapeutic methods used in treating Holocaust survivors were being discussed (twenty to thirty years after the war), isolated examples could be found of the avoidance and denial that characterized the way mental health professionals in Israel were dealing with "those who had returned from death". In discussing their own reluctance to face the Hololcaust, Williams & Kestenberg (1974) wrote on the latency period that had to be traversed before one could give up the denial and repression of the unspeakable terror. Moses (1987) spoke of having been, with others, "a partner to the denial of the impact", not only of the Holocaust but also of several wars that threatened the State of Israel. It has been assumed that patients, along with the society to which they belonged, were attempting

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leben der Menschen in Israel. Die psychische Gesundheit ist deshalb buchstäblich auf Messers Schneide: Einerseits ist volle Realitätswahrnehmung eine Grundlage seelischer Gesundheit, andererseits kann unter gewissen Umständen ein gesundes seelisches Funktionieren nur unter Einsatz von Verleugnungsmechanismen gesichert werden.

Die gemeinsam verleugnete Realität dringt immer wieder in den Behandlungsraum ein. Es muss sorgfältig bearbeitet werden, wie das Eindringen äusserer Realität als Abwehr gegen die Wahrnehmung innerer Realität benutzt wird und wo das Fixiertsein auf Inneres der Verleugnung äusserer Gefahr dient. Ein ständiges Hin-und-Her-Pendeln der Aufmerksamkeit ist im therapeutischen Prozess notwendig.

Die Auswirkung der alltäglichen Gewalt zeigt sich auch in der Schwierigkeit, Gruppenprozesse fruchtbar zu gestalten. Die Tendenz zu Projektion und Spaltung kann unter dem Druck des Traumas übermächtig werden.

Die Autorin zeigt anhand von Fallbeispielen auf, wie sie immer wieder versucht, die Fragmentierung zu verhindern und eine kohärente Erfahrung herzustellen. Wichtig ist dabei, die individuelle von der kollektiven Erfahrung zu unterscheiden, auch wenn dies noch so schwer ist.

Sie betrachtet den Behandlungsraum als einen Ort der Hoffnung, in dem die harte Realität gehalten und ausgehalten und in Gedanken und Worte gebracht werden kann. „Hoffnungsarbeit" besteht in der Konfrontation mit Bedrohung und Schmerz und dem daraus resultierenden seelischen Wachstum. Heitere Ernsthaftigkeit (serenity) ist die richtige therapeutische Haltung.

PsychotherapeutInnen, die sich in der Arbeit mit Bedrohung und Trauma engagieren, werden für ihre Mühen durch innere Bereicherung belohnt. Sie schätzen ihr Leben mehr und beziehen Lebenskraft, Inspiration und Hoffnung aus der Begegnung mit dem alltäglichen Mut ihrer Patienten. Sie lernen „Integrität", Lebensbejahung im Angesicht des Todes, Respekt vor den tragischen Begrenzungen des Lebens.

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to avoid personal confrontation with "the extreme", and with hidden feelings of mourning, rage, shame and fear of death, experienced by both the therapist and the survivor (Davidson 1980).

Keinan-Kon (1998) pointed to a similar phenomenon which accurred during the Gulf War. Her paper (written seven years after the Gulf War) is one of few exceptions (Berman, 1991; Molad, 1991; Stern, 1992) that dare to raise the question: "When analyst and patient alike are threathened by the same traumatizing reality,is it possible to bring back to the common symmetrical factual reality, the asymmetrty necessary for the therapeutic space?" (ibid, p. 440).

Nonetheless, I believe in what Lipton (1978) and Lindy (1989), who worked with Vietnam veterans, wrote that without an awareness of counter-transference and its power, it is impossible to enter into meaningful therapy with survivors and comprehend their unexpressed pain; nor is it possible to arrive at a meaningful understanding of the unique forms of evil in our times. Therapists must be willing to reconsider social and scientific values they have believed in until now. For us, this means confronting our fears and our hopes about our own death and survival, including our professional survival (Lipton, ibid).

I would like to demonstrate, by an almost daily example, how external reality interferes with the effort to think and function psychologically. That morning I was on my way to the office, when my flow of associations was suddenly interrupted by the news broadcast about a Palestinian suicide bomber who murdered 19 people and wounded some 70 more. He exploded a large, nail-studded bomb on a bus in Jerusalem, full of school children and commuters. The force of the explosion sent bodies flying from the bus, which, in seconds became a charred skeleton. I have to admit, that I was flooded with unthinkable emotions. I became enraged, anxious and hateful, unable to sympathize with those, who at this moment, are our worst enemy, but whose children are the victims of the hopeless poverty and cesspool of their lives. A day later, another bomber blew him up at a bus stop on a busy crossroad near my house.

The hypothesis of this paper is that the therapist's identity is formed in a cultural context, and therefore, the col-

lective narrative and the associarions connnected with it will be be an insepareable part of this context. In Israel one of the fundamental themes that comprise the national narrative is war and coping with it. This shared destiny has many implications on whatever happens in psychotherapy, especially during a period of real threat. Obviously, more intense feelings are aroused, and therapists are confronted by moral and humanistic questions they usually avoid in order to maintain the analytic stance. This article will deal with the difficulty faced by therapists and the manner in which they must shift back and forth between the collective contents they share with the patient and the patient's unique contents.

On the thin line between the therapist's personal and collective story

Who is that therapist, that representative of mental health, the subject who treats? Like most Israelis, my personal history is intertwined with the collective history of the country.

Israeli life is marked by two pertinent characteristics: the distance between the home front and the war front is not great; and the Israeli army is a civilian army, so that almost every family has a father, a son or a daughter serving in it. Israel is a country where such developmental stages as separation-individuation, adolescence and the formation of sexual identity are firmly linked to army service. Serving in the army is a developmental stage every family treats as significant, anxiety provoking and threatening. I remember a patient of mine, the son of Holocaust survivors, who felt ambivalent about the birth of his own son because when the time came, he would have to go into the army. I don't believe there are any parents in Israel who do not have these complex feelings while raising their children.

I was born a year before the establishment of the State of Israel to a father, a staunch Zionist and a mother, a Holocaust survivor, silent about her past and those parts of it that were permeated with horror.

I find that the various collective wars fought by Israel have a special place in my personal memories, serving as sta-

tions in time, as in an initiation rite: As a child, I saw a film, about children evacuated to a boarding school that was under threat during the War of Independence (1948), and I remember being scared by frightening moments in the film – perhaps evidence of pre-verbal experiences I had as a baby during that war. Or the moment the door of our house opened and my cousin, an only son who was rescued and brought to Israel by my mother, entered, dirty and exhausted after the Sinai War (1956). I remember my mother crying because yet another battle had ended successfully. From there he returned to his home, which was surrounded by a protective fence, in the Jordan valley, to his children, who had been born and raised in air raid shelters.

In the Six Day War (1967), I belonged to the age group that lost childhood friends during regular army service.

The Yom Kippur War (1973) is etched in the Israeli national consciousness as an enormously traumatic event. By then I was a psychologist, not very experienced, certainly not in the treatment of battle fatigue. I remember Nachman, an officer in the paratroopers, who was sent home to recuperate from battle fatigue. He was visibly agitated and hypomanic. In a session with him, I looked at pictures he had taken during battle to enable him to undergo abreaction and catharsis and to organize the apocalyptic narrative. Nachman was one of those soldiers we clearly had to help pull himself together as quickly as possible and send back to a different unit, not the one that had been dismantled. Our parting was emotional. For many months, I was unable to escape the obsessive need to read obituaries as a way of coping with the impossible job of treating a person to prepare him for battle and perhaps death.

After six months of frenzied work in the army's convalescent facilities, I continued treating post-traumatic soldiers as a psychologist in the military mental health clinic, whose horrifying descriptions I remember to this very day.

In the Gulf War in 1991, all of us were again faced with a new situation, one we had not dealt with in the past. Confronted by the threat of toxic gases, invisible bacteria and conventional missiles, with a warning time of less than five minutes, we felt that our

homes were no longer our castles. In retrospect, the effort involved in choosing a room in our homes to seal off with tape and rags seems absurd, grotesque, horrifying. And one does not have to be a Holocaust survivor to be shaken by the sight of showers placed in the front yards of hospitals to wash off potential victims. We were going back into history, to experiences that belonged to the personal and collective past, experiences we had managed to repress.

At the time of that war, I already had young children. I not only had to keep on functioning and protecting them, but I also held a responsible position and people depended on me to help them cope.

And then Rabin, the architect of the peace process, was assassinated. The universal manifestations of mourning were certainly the best example of how distinctions between the personal and the collective become blurred. We were all shocked and confused, surprising ourselves with our our expressions of grief and solidarity with the Rabin family. An entire country sat *shivah* around lighted candles, armed with guitars and humming "The Peace Song". Rabin symbolized leadership, who projected confidence and authority, a father figure. He represented our desire to break away from the past, to believe that it was possible to turn war into peace. For many, his death symbolized the death of the peace process and the death of hope. Even though feelings towards him were ambivalent when he lived, he became idealized after his death.

During the first few weeks, both external and internal reality were present in the psychotherapy room. Personal feelings blended with collective ones. Patients talked about their murderous feelings, their anxiety, their guilt feelings, as if death wishes had come true.

Again stations in time: eighteen years in Lebanon that cost lives daily. The Mothers' Revolt, the retreat from Lebanon, another moment of illusory hope, perhaps a sign of the end of hostilities in the area, a transitory feeling that my son, soon to be drafted into the army, would be saved ... and then the Al-Aqsa Intifada that suddenly brought back the profound anxiety that we were facing eternal war, a hundred more years of conflict and of the danger of all-out war. Daily terrorist's attacks every were and hundreds of victims turn

threat and fear into a constant presence, but in addition, this time there is no safe place to escape to. Everything becomes so personal. With the Israeli mentality, in a country as small as ours in which everyone knows everyone else, if you don't actually know the victim, then one of your acquaintances surely does. The fear no longer creeps into the psychotherapy room, but bursts headlong into it. The knowledge that any of us could be a victim in one way or another has seeped into our consciousness.

Conscious and unconscious collective identity

Nations are "born" differently. Shared realistic or fantasized perceptions of the past and the manner in which a large group's identity was established, influence common attitudes and actions within a given society.

The sociologist Ben-David (1962) believes that particularly during the formative years of Israel there was "a nearly perfect harmony between individual values and the needs of the collective" (ibid, p. 408).

From the psychoanalytic point of view, the Jewish people can be seen not only as a socioreligious group, but also as a group united by common trauma. Jews are admonished to remember their ancient and recent history of persecution. Paradoxically, Holocaust survivors were expected to forget with no way of mourning their indigestible loss. This is the reason why beyond the so called normal development, the unspeakable trauma of the Holocaust stamped itself indelibly on the national psychology of the New Country, and the memory of the inferno permeated all levels of society (Davidson, 1985; Eilon, 1981). Gampel (1987, 2000) introduces the concept of "radioactivity" to describe how the effort to bypass traumatic events by denials does not only nestle itself in the victims' inner world, but is transmitted within the family and to future generations.

The dream that the new homeland will supply a "heimlich" – "background of safety" (Sandler, 1989) soon turned into a nightmare. Constant wars turned it to Freud's "unheimlich" – the "background of dread and horror" or the "uncanny", as Gampel (2000) uses the concept.

Au-delà du concevable : le patient et le thérapeute dans le même collectif

Résumé Dans son article, notre collègue israélienne traite des difficultés rencontrées par le travail psychothérapeutique lorsqu'un traumatisme collectif touche inévitablement les deux partenaires de la dyade. Elle part de l'hypothèse que l'identité de la psychothérapeute est formée par un contexte collectif et ne peut pas en être séparée. Elle examine dans ce sens la manière dont les problèmes affectant l'existence en Israël influent sur son travail : comment des fantasmes et expériences collectives, partagés par patient et thérapeute, peuvent-ils être traités séparément de ce qui fait l'individualité des partenaires ?

Elle décrit d'abord l'expérience des thérapeutes israéliens, dont l'histoire individuelle est étroitement liée à celle de leur pays. Tous les Israéliens entretiennent une relation émotionnelle avec l'armée et le sentiment de menace individuelle est directement associé à la menace subie par le pays. Savoir qu'on peut en tout temps être victime de la violence est une dimension vécue consciemment par tous.

L'identité collective du peuple juif ne se fonde pas seulement sur sa religion et sa culture, mais aussi sur les traumatismes collectifs qu'il a vécu. En plus des rituels célébrant le souvenir et le deuil, on rencontre un fort besoin d'oublier et de nier les effets du traumatisme. Les habitants d'Israël utilisent donc des mécanismes d'adaptation basés sur le déni, le rejet et la fuite dans la normalité du quotidien. Leur santé psychique ne tient littéralement qu'à un fil, celui qui sépare une perception adéquate de la réalité, indispensable à la santé, de l'utilisation de mécanismes de répression permettant de fonctionner de manière appropriée.

La réalité déniée par le collectif est fréquemment présente dans l'espace thérapeutique et beaucoup de travail doit être fait à ce niveau, l'attention se portant alternativement sur la réalité extérieure et la réalité intérieure. La violence au quotidien fait aussi qu'il est difficile de construire des processus de groupe, car la tendance à la projection et à la dissociation est renforcée par la pression du traumatisme.

L'auteur présente des exemples de cas pour montrer comment elle tente constamment de prévenir la fragmentation et d'aider ses patients à élaborer un vécu cohérent. A ce niveau, il est essentiel d'effectuer une distinction entre l'individuel et le collectif – essentiel, mais très difficile.

Elle considère son cabinet comme un lieu d'espoir, où la dure réalité peut être contenue, exprimée et supportée. Le « travail d'espoir » consiste en une confrontation à la menace et à la douleur, mais aussi et finalement en un développement du psychisme. L'attitude thérapeutique adéquate est celle de la sérénité.

Les psychothérapeutes qui travaillent avec des clients subissant des menaces et des traumatismes en ressortent enrichis intérieurement. Ils apprennent à mieux apprécier la vie et le courage de leurs patients leur fournit de l'énergie vitale, l'inspiration et l'espoir. Ils font l'apprentissage de « l'intégrité », du choix délibéré de la vie face à la mort et du respect des limitations tragiques de l'existence.

More and more victims pushed the society to help its members cope with death. The term "Family of Bereavement" reflects the importance the Israeli society accords to the death of its young people. On Israel's annual days of commemoration the community mourns together. Once a year on Memorial Day, at precisely 11:00 a.m., a siren sounds throughout the State of Israel and the flow of life stops for two minutes in which citizens stand in attention and remember the victims of war. Although researchers in Israel take different theoretical perspectives, they commonly share the view that the ceremony is a central practice in the process of forming the Israeli-Jewish nationality (Lumsky-Feder, 2002).

Nevertheless, it seems that intertwined with remembering and mourning is a most prominent dominant desire to forget, to "clean up" the evidence of destruction, to be reborn into normal life. After the massacre in an Israeli hotel, were people sat to celebrate the Passover meal, the New York Times Magazine described, what seems an Israeli inclination, how fast the place was cleaned from any sign of the catastrophe that occurred the day before.

Though denial helps to go on living, on an unconscious level, there is a high price to cumulative trauma (Khan, 1981; Berman, 1987). And the price is that we cling more and more to the fresh collective memories.

On this basis, it can be hypothesized that in Israel the "radioactivity" of trauma also leaks into the intimacy and safety zone of the analyst's consulting room, and that the anguish becomes intermingled within the inner worlds of both patients and therapists.

Denial, disavowal or escape to normality?

Observing daily life in Israel over the year creates the impression of normal existence disguising the terrible price of life in constant war. To an outside observer we might even be seen as indifferent, obtuse or alienated. This kind of defense mechanism marks all sorts of strange "defensible borders". When katyushas missilles fell in the northern part of the country, some 250 kilometers from our home, the danger could be denied. When a bus exploded in Jerusalem, some 60 kilometers from our home, denial still worked. But when the explosion took place on the corner of the street our children cross every day, denial was much more difficult.

A once commonly accepted psychological hypothesis claimed that mental health means being as clearly and precisely aware of reality as possible. However, studies of denial over the last few years also indicate the positive effects of denial and even the existence, in certain situations, of illusion (Breznitz, 1983; Lazarus, 2000). Furthermore, invasive therapy techniques that confront denial constructs,in order to remove them, are liable to have the opposite effect and to lead to the use of even more distorted denial constructs (Breznitz, ibid).

It is always astonishing when patients come into the room and begin speaking, with the utmost naturalness, about the emotional agonies of their inner world without saying a word about the external reality, without the need for even a transitional comment. More than once, the question arises of how to respect patients' choice, without wondering about their coping or alternatively, without pathologizing projected guilt and anxiety. We are all familiar with the fact that certain people feel a sense of emotional well being

during periods of external danger. Besides, this ability may actually be evidence of positive developments in the therapeutic process and of the ability to work things through in the inner theater of the mind rather than in the dramatic arena outside.

And what about the therapists? We can assume that they are also not immune to denial. How will therapists' denial affect the space left for patients to deal with what is troubling them? After all, it is well known how much unconscious power and influence therapists have on patients.

A psychotherapy group is meeting in a city where many terrorist attacks have occurred. In a supervision session, the group leaders are surprised to realize the extent to which content related to external reality is absent from the group's discussions, and they wonder about its meaning and their part in it. In one session, as they are discussing self-actualization of femininity and masculinity, the air quivers with the frighteningly powerful booming sounds of planes breaking the sound barrier. One of the participant's attempts to draw the group's attention to the sounds coming from outside, are interpreted as an effort to run away from the explosive sounds and drives inside her and move far away to what is happening in the sky. Only through supervision does one of the group leaders become aware of the sense of dread also threatening to overwhelm her at hearing the noise, and perhaps of the urgent need to summon up denial in the face of such a complex reality, even if that means limiting her perception.

Freud (1938a, b) tentatively distinguished between repression and disavowal which is directed against external reality. Freud related to disavowal as a split in the ego, and as defining circumstances where an individual proves adept at keeping two apparently contradictory ideas in mind, without feeling the obligation to reconcile the two. Unable to assimilate the traumatic reality, the person splits his ego, disavowing his perception of this reality.

Kübler-Ross (1969) describes the response of terminal patients that suddenly hint they can no longer continue looking at reality as it is, and temporarily cling to denial. At an even later stage patients use splitting instead of denial. They can talk about their health and their illness, about their life and their death, as if these were twin entities entitled to exist side by side. In this way, they can confront death and still keep hoping.

Spiro (1987) formulated the concept of "culturally constituted defense mechanism". This concept is crucial for understanding the subtleties of the use of defense mechanisms where the content is heavily drawn from collective representations.

Are we – patients and therapists – taking part in a "conspiracy of silence" so typical of Holocaust survivors? Do we choose to ignore reality because we feel caught in an impasse? Is this nothing more than a healthy process, the only option possible, preserving the inner continuation of the self in terms of "going on being" (Winnicott, 1949)?

Intrusion of external reality or overlapping worlds?

When patient and analyst are both exposed to the same traumatic circumstances, they share a common external reality and their worlds overlap.

The patient and I listen together to sounds we have learned to recognize – sirens or rescue vehicles. We both have a low stimulation threshold and jump even when a door slams or the rumble of a motorcycle cuts through the air. Not only is the patient's fear exposed, but the therapist's as well.

A patient is talking about the fact that there can be no consolation for the loss of her first husband, who was killed in a car accident three months after they were married. It is 4:15 in the afternoon. From a neighbor's blasting radio, news of another attack penetrates our room. The patient turns to me and says, "I wish I could postpone the news of the latest catastrophe for another hour, freeze reality for a while". I too feel that way. The session ends. The patient forgets her sunglasses. At 7:30 in the evening, after seeing the horror on TV, I find myself calling my patient to tell her she forgot her sunglasses – something I would not necessarily do under normal circumstances. Was I trying to say that both of us are aware of the terrible things that happened after our session? Was I trying to say that the images were so awful that perhaps we needed sunglasses to cover our eyes? Or maybe my call was an expression of therapeutic loneliness and the need for contact?

On Commemoration Days, at the sound of the two minutes' siren, both therapist and patient will unquestioningly get up and stand at attention. However, this unique experience con-

cretely exposes the intrusion of the collective. Comparably, the recent presence of mobile telephones in the therapeutic hour introduces new challenges. The shared anxiety concerning children's safety and the need to be constantly in touch, poses dilemmas such as: does the turned on phone protect the therapeutic potential space or violates it? What about symmetry and the therapist's need to be informed if something happens to his family?

Even experienced therapists and analysts, usually careful to preserve the boundaries of therapy, find themselves crossing the lines, tempted into acting. Dasberg (1987) even suggests the concept of "social counter-transference" to describe such a process. Keinan-Kon (1998) describes how she bought, in the Gulf War, a second gas mask for a patient who refused to bring his to psychotherapy, because she could not bear the possibility enacted in the situation of a forced-choice decision along the lines "one to life, one to death".

The following example demonstrates how patients and therapist are ensnared in their overlapping personal and collective "net of signifiers" – the inevitable process in which anxieties, expectations and hopes are transferred throughout generations to the children, who absorb that ceaseless flow of unconscious, cumulative trauma.

A couple comes for advice about their five-year-old son, who suffers from anxieties. He is the oldest of their three children, with two younger sisters. The mother talks about the anxiety and special feelings she has for this child. Almost offhandedly, she mentions that he was born after she had suffered a miscarriage. A month after the birth, the Gulf War broke out. The father was doing reserve duty at the time, and when she put the newborn into the protective "tent", he almost suffocated. I find myself thinking about my daughter struggling with her gas mask, vomiting continuously, and about the way we protected our children with our own bodies during a missile attack when we were in our sealed room, which offered no defense against conventional weapons. In our next session, when I asked the parents to tell me something about their personal history, I learned that the mother had been nine when her older brother was killed trying to save the lives of other soldiers by throwing himself onto a live grenade. The couple had planned to name the miscarried baby after the deceased brother. Later, when their son was born, they chose a different name, perhaps in an unconscious attempt to save him from a similar fate.

Projection or dialogue with the "other"

One of the most liberating aspect of psychological treatment is the avoidance of moral judgment (Forster, 1997). Generally, analysts are not accustomed to analyzing their political positions and political "counter-transference" and hence rationalize their insecurities by a kind of phobic avoidance.

The political and social situation in Israel makes it impossible to remain a neutral observer and we are constantly required to touch the boundaries of our tolerance. We may assume that when one entry in our collective dictionary is "extermination of Jews" in the Holocaust, a war of survival, Palestinian animosity towards Zionism – our thoughts become more dichotomous.

As people in general, and as mental health professionals in particular, we are constantly required to ask how empathetic we can be to variances, to the "other". There are many "others" in Israeli reality: idealistic settlers and ordinary people in search of a better life in the disputed territories; ultra-orthodox who do not serve in the army, but do the sacred work of collecting the pieces of dead bodies of victims in order to bring them to proper burial; secular people, left-wing urban sophisticates; new immigrants; Israeli Arabs and, of course, Palestinians.

Klein-Halevi (Another Country Magazin 2001) writes that "while in other countries, the differences between Republicans and Democrats focuses on the nation's welfare, in Israel political discussion focuses on the country's survival". We live in an ironic political, and situation: What for Palestinians is a background of safety represents an uncanny background to Israelis, and vice versa. The background of safety for left-wing Israelis and Palestinians represents the uncanny to nationalists of both sides.

I think that not only do we find it difficult to observe the Jewish edict "Love Thy Brother as Thyself", but find it difficult to keep in mind the fundamental law that "Man is Created in God's Image".

An annual conference of psychologists. It is taking place in December, some two months after the outbreak of the Al-Aqsa Intifida, at a time when the settlers in the territories feel that they are sitting ducks for terrorist attacks, and after the October riots, when twelve Israeli Arab citizens were killed by the police. Naomi is the only participant who lives in the settlements. She talks about how her participation in the group had merely solidified the feeling that she arrived with-being isolated, rejected, demonized by the group, a feeling which represents the way most settlers feel. Being marked as an obstacle to peace, she says, there are even people who gloat at their suffering. In a matter of minutes, the group members are actually reproducing the attitudes she has described. Alona, the only child of Holocaust survivors, is very angry that her son, a soldier, is serving in the territories and endangering his life guarding the settlers. Rachel, who had lost her husband and father in a terrorist attack many years ago, is outraged by Naomi presenting herself as the only victim. Galia is sure that emotions cannot be separated from the political debate. She grew up in a kibbutz, and who knows better than her, how much a part of structure ideology is.

As the leader, I feel torn, but mostly paralyzed. The split between left and right exists in my extended family. We avoid visiting our relatives in the settlements, abstain from heart to heart talks. My thoughts wander to a patient of mine who became clinically depressed when she moved to a settlement, a move which opened ideological, emotional and existential chasms in her. I recalled her childhood fantasy in which she was marching at the head of a group of children who would make peace with the Arabs. I return to Naomi, feeling angry and finding it difficult to empathize with her pain and anxiety. The session ends in emotional chaos.

During the lunch break I try to empty my mind and heart of all the noise, and I feel that, at the beginning of the next session, I want to say to Naomi: "Don't tell me something big and important, just tell me something small and idiotic". And that's what I do. The intervention seems artificial, but she agrees and chooses to talk about a children's story she is reading. This is the turning point. A part of the fortress wall is breached; Naomi begins talking about her fear that her children will be orphaned, about her wishes and hopes. The others in the group can now show empathy and not leave her in isolation, and can bear the complexity.

The exhausting session ends. All the psychologists are invited to a dialogue with our Arab colleagues, who speak fervently about their identity dilemmas, ongoing discrimination and feelings of humiliation. They couldn't understand how their Jewish colleagues did not even call them while they were coping with the emergency situation in their schools. Once again, I am emotionally torn. I try to balance the voices, to contain them inside me, by identifying on a certain level with all the various sides, but in fact, not with any of them. This example indicates how easily mutual, collective, apocalyptic fears can penetrate a group and threaten its integrity. Group leaders must undergo an internal process if they are to find, in all that chaos, an empathetic, human approach towards the human, small things in life that we all share.

From repetition to unique experiences

Psychoanalysis has dealt with the repetition phenomenon (Freud, 1912). The compulsion to repeat is an action originating in the unconscious and it replaces the inability to remember. As a result of its action, the subject deliberately places himself in distressing situations, repeating an old experience, without recalling it as a prototype; on the contrary, he has the strong impression that the situation is fully determined by the circumstances of the moment.

Only listening to the concealed story enables us to understand what makes our world unique within the collective bond. In order for the therapeutic process to take place, extra care must be exercised in establishing the difference between each side's subjective reality. In the following example one may also ask how the specific therapeutic session contributed to the transformation from fragmentation to coherence, from despair to hope, from death to life.

A patient, second generation Holocaust survivor, born in Israel, the mother of grown children, has been living for years in a border kibbutz. She came to therapy because of inexplicable catastrophic anxieties and feelings of insecurity. Many times in the past, she has expressed concern about terrorist attacks with relation to her children, who live in large cities. She is also preoccupied with the dominance of her mother and sister, who continue to treat her like a child, and with her supposedly ancient guilt about other people's catastrophes (Holocaust, bereavement), of which she had been spared.

Not too long ago, this patient, who is herself a psychotherapist, was called upon to intervene in the post-traumatic situation of an entire community. In our therapy, I feel that she is becoming overburdened. A short time later, while she is in session with a patient, terrorists begin shooting at people in the street. She hears the shots but the patient continues talking. Later, the psychotherapist receives phone calls from many patients, some of them post-traumatic, asking for encouragement.

She is depressed and frightened in our session, two days later, reliving those fearful moments with her patients, looking at me for an answer. It seems strange to her that she is frightened for herself, and not for her children. She says, smiling a bittersweet smile, "Maybe it's a good sign that because of therapy, I've started thinking more about myself". She recalls that when her son was a baby, she would cover his bed, which was opposite the door, so that if terrorists broke in, they would not realize that a baby was lying in it. At this stage, I too feel unfocused. My mind drifts to the dreadful memories as well as communal old memories Israelis have of Smadar Haran, whose house was invaded by terrorists and to the death of her two children, suffocated in her effort to keep them quiet. I am thinking about the Holocaust and similar impossible parental dilemmas.

Should I tell the patient about my associations? Would that be of any benefit? I feel the need to say something natural, something about my own fears on that day, when every news broadcast mentioned that the police were searching the area I live in, to avert terrorist attacks. I wanted to say, as my patient had said to her own patient directly, humanly: "Yes, I'm afraid too and I don't have an answer either." Maybe, she says, she only needs "a day off" from the events, and I add, "Maybe a week," exactly the same advice she offered to her own patient. She smiles.

In my mind, I try to connect the contents of this session with the previous ones, when she had been full of life, looking elegant, wearing jewelry she had recently bought for herself. Finally, I say something about the intermediate stage, when she can no longer protect her grown children and separate from them, when she is no longer her mother's little child. But now that she is the one facing danger and death, she can use her own vitality and vigor. I detect a sense of relief. And she says, "That's interesting, do we have time left? Because that's exactly what I wanted to talk about, about how I can maintain a relationship with my mother and sister, but be free of them too."

Perhaps, beyond containing, what enabled the transformation from fragmentation to coherence was the interpretation that separated the collective from the personal, and separated her from her past. Only against such a background could her own vitality emerge.

What about hope?

Perhaps in this time of uncertainty and fading hope, when future's perspective is becoming limited, we should return to a discussion of hope and its meaning. When the mythological Pandora opened the box, releasing all the troubles and catastrophes mankind would be subject to, hope appeared along with them. Hope, after all is the subject and object of our national anthem, in which it seems to express our longing, our heart's desire. However, in contrast to passion, hope does not demand immediate gratification or actual fulfillment. Rather, it is a potential, with no boundaries of time and place, and it loses meaning the moment it is realized.

During recent years, hope and its positive effect on functioning is being discussed in the wake of reports by people who, through will power and struggle, survived terrible experience, whether in concentration camps (Frankl) natural disasters (Henderson, 1977) and in coping with disabilities and severe illness (Cousins, 1979; Miller-Florsheim, 2001). Meninger (1959) considered hope another aspect of the life instinct, the creative drive struggling against destructive forces impelled by death instinct. He distinguishes between hope, expectation and optimism, claiming that optimism is not based on correct evaluation of obstacles, and tends to minimize their power, thus moving away from reality. Hope, on the other hand, is more selfless, and therefore more anchored in reality and forward looking. Meninger believes that one of the doctor's function is to instill the proper amount of hope, any hope, as long as it is not exaggerated.

Jacby (1989) propose speaking about "the work of hope" by which she means a process that requires action, exposure to and confrontation with threat and pain in attempt to cope with them. She does not mean actual physical action, but rather the possibility of cognitive, psychic action based on the belief that the work of hope enables growth, development, a sense of control and coping. Breznitz (1982) speaks of "hope as a protected area". He writes: "In the stormy sea of worry, anxiety and thought, man searches for, and sometimes finds, an island where it is a bit quieter, and tries to reach that island and to stay on it ... and I allow myself to express the idea that perhaps the movement, that embrace, in which a parent holds and protects the child, envelopes him, presses him close, is the beginning of hope" (p. 15).

The psychotherapy room as a protected space

Idealy, the psychotherapy room will serve as a protecting, containing space, neither exposed nor sealed off, as a place of respite, an island of sanity and hope. It seems that a patient coming for therapy during a time of national crisis expects to find a protected space, a "protective shield" (Kahn, 1981) in the psychotherapy room and expects to find in the therapist both a functioning and a soothing parent. In such times of overwhelming anxiety, of chaos and fear of annihilation, patients can show regressive behavior and a desire to be protected from the evil and the threat. However, therapy must provide them with the possibility of an encounter with an impossible reality. Following Winnicott, we can say that man's life is an ongoing process of the rational acceptance of its boundaries, a cumulative process of disillusionment and of mature mourning. (Kolka, in Winnicott 1996). The therapist, like the parent, must enable this movement between illusion and disillusionment, must protect patients from cumulative trauma by screening and regulating, both external and internal stimuli, in such a way that will enable them to grow from a life of mere survival to a meaningful, creative one.

Another therapist's major functions is to survive in the face of the evil and atrocity confronting everyone in the psychotherapy room, and reconnect with all that is human and bearable, so as to provide patients with the opportunity for an integrative experience of the human and good. Hopefully, therapists will be able, like mothers, without being destroyed, feel the pain and then feel other things that emanate from body and soul, not all of which has been damaged, and transmit to their patients the feeling that the whole world has not turned into pain, sorrow and evil.

However, most importantly, when therapists and patients find themselves in a shared world, or in Buber's words, in the *interhuman* sphere, therapists must connect with their own humanity, in an "I and Thou" encounter with their patients. They must posses a kind of serenity that will allow them to live the harsh reality and not rush into interpretations. Both patients and therapists must guard against the natural tenden-

cy to cover up pain, rifts and helpless-ness with supposed "understanding" that blunts the senses. It is precisely in the questions of life and death, of the finiteness and infiniteness of life, that we find the potential for healing. This means that therapists – without burdening patients with their own personal problems – should not be afraid to be present as subjects, with their own associations, experiences and feelings, which are an inseparable part of the therapeutic dialogue (Miller-Florsheim, 2001).

Psychotherapists are compensated for their involvement by the feeling that their life is enriched. Those who treat trauma victims report that they value life more, understand others and themselves better, and feel that the daily examples of patients' courage, determination and hope is an inspiration for them (Herman, 1994). Erikson (1950) uses the term "integrity" to describe the ability to affirm the value of life in the presence of death, to become reconciled to the finite boundaries of human life and its tragic limitation, and to accept this reality without despairing. One may say that involved therapists deepen their integrity through the constant nurturing of their own and their patients' integrative ability. If we adopt Erikson's words, we will agree that healthy children do not fear life if their parents' integrity is sufficient to keep them from fearing death.

Summary

It is possible to relate to Israeli society as a modern tribe in which collectivity and the collective ethos were elements used in the construction of general and personal identity. The hypothesis of this article was that the therapist's identity is also formed in a cultural context, and therefore, the collective narrative and the associations connected to it will be an inseparable part of it. One of the central and fundamental themes that comprise the national narrative is war and coping with it. Today, at a time of continuing national trauma, the therapist too share in cumulative traumatic experiences. In a period when the difference between the home front and the battle front is blurred, the boundary between therapist and patient also becomes blurred, and each of them, like of all of us, is a potential victim. Therapists are not just neutral observers, but rather anxious, concerned partners who are themselves sometimes injured.

This article discussed the implications of life in uncertain times, the therapeutic space, and the therapist's space. The assumption was that external reality intrudes into therapy – whether we are conscious of it or not – and can damage therapists' ego functions. Obviously, more intense feelings of countertransference are aroused, and therapists are confronted by moral and humanistic questions they usually avoid in order to maintain the neutrality of the therapy.

Many unanswered questions still remain: As a person facing a terrible reality, I ask myself if through my psychoanalytic understanding I will be able to make a small contribution to the ever asked question: "why war?" What happens when the individual's worst personal fantasies are confirmed by reality? How relevant can the prevailing psychological language be? Does the theorethical insrument allow for the formulation of theories about external reality? Can we imply from the individual therapeutic process into the social reality?

Do psychoanalysts have an urgent plea in active efforts to halt such "mad" processes? "Is silence the real crime" as Hana Segal cites Nadejda Mandelstam?

The conflict between us and our neighbors and the current war against terror clearly demonstrate that it's time to leave behind the collective identity. On the therapeutic level we tried to show how only separation of collective from personal and past from present enable growth.

But can Israelis and Palestinians avoid the compulsion to repeat the indigestible trauma and turn it into a representational memory? Can the two peoples disengage from their past and convert the command "never to forget" into a symbolic monument which enables remembering?

We also tried to demonstrate in a small group how easily are we trapped into looking at the other through our own projections; how easily potential violence and automatic response based on force can arise, and how many efforts should be invested in trying to emerge from such positions to create a dialogue.

Do we have genuine leaders who might extract both peoples from their lethal routine, were they continue to wallow in their violent intransigence, seek to vanquish the rival rather then compromise with it, and cheapen the value of human life? Only a society whose members are mature enough to hold ambivalence, is a society, which enables the existence of the other. Only in such a potential space will we be able to grasp, if only for one brief moment, our common basis of humanity.

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