The collusion that Ron and I co-created to fend off anxiety borne by aggression bred zones full of goodness that had to be protected from emptying. There is a sense of potential contamination (Gerson, 2009), and the "healthy" parts have to be protected in solitary confinement. The unconscious collusion is therefore a mutual agreement between the two of us (each containing both a victim and an aggressor simultaneously) that the aggression poses a threat to each other and to the treatment. Together we summon the "guard" who obstructs the language of passion and aggression, only granting entry to the enigmatic language of tenderness as a means of preventing retraumatization and protecting parts of each of the participants and of the treatment. But the trauma, attack, and humiliation were always there, and the treatment did not survive.

Ron and I separated, each of us holding the good, but also the bad and empty parts of the treatment. A few years later, when I ask Ron's permission to write his story, he comes to one more session and asks that I read him his story. He wants to listen to my voice instead of reading my words. He explains to me that, as with his dead father, time passed and our narrative has become dull, empty. He asks to use my writing of his story as a way to hold something not only from his analysis, but also from his life. We speak about my words, my narrative that aims to preserve his narrative but that in so many ways, as it is in this writing, is a representation of my own mind as much as of his mind. This story, similar to other clinical tales, is his story as it resonates in my mind. But to some degree, my reverie and my words, as they appear in the analysis and in writing, are also potentially the container of the patient's mind. For Ron, the actual words were not particularly important. What was important was that I hold him in mind, that I construct and de-construct, create and re-create his story, his life, and hold it within me.

Note

1 *Analyze This* is a 1999 gangster comedy film directed by Harold Ramis, who co-wrote the screenplay with playwright Kenneth Lonergan and Peter Tolan. The film stars Robert De Niro as a mafioso and Billy Crystal as his psychiatrist. A sequel, *Analyze That*, was released in 2002.

Chapter 7

Karen

Words and silences

At noon, a young woman phones me, introduces herself, and starts crying. She says that she was referred to me because a terrible thing has happened. She does not know what to do. "I am probably either a horrible person or crazy. Tell me I'm not to blame. Please, tell me that it's not my fault." She breathes quickly and adds, "Even if you told me it wasn't because of me, I'm not sure I'd believe you. I feel crazy. I don't know what to do." Karen tells me that she had been in therapy with Dr. A for six months when it all began. He took a month-long vacation, and that is when everything started imploding. When we first talk, she is preoccupied with the object's death, her destructive power, and wordless breakdown. Using words as an enactment, this chapter will explore fantasies related to the destructive power of need, including the fantasy of weaning from the object as from drugs, food, or alcohol, the confusion between love and hate, murder and abandonment, and this confusion as expressed in the therapeutic dyad. The chapter concludes with the patient's response to this story.

Karen's tale begins with an actual abandonment that gives rise to enormous anxiety and rage. As we shall see, Karen returns to her primal solution—control, power, and importunity—which covers her feelings of dependency and helplessness. Karen speaks of the need to maintain control so that the pain of abandonment will not crush her. Words are one way to enact those feelings and thus are not only a linguistic episode, but also an intersubjective encounter, as enigmatic knowing is transmitted in and between the actual words (Joseph, 1985). I discuss the way Karen uses words to attack but also connect with her therapist, and how she implores him to release her from the guilt of his murder, from her anxiety about her own aggression. When she does not succeed and realizes that the connection will not be revived, she understands that something irreversible has happened and that she cannot repair what has gone wrong in the relationship. It is at this point that she becomes aware of a wish to repair herself and to put an end to the transgressions she believes she commits.

Reunion and reparation

Reunion was the focus of Ainsworth et al.'s (1978) development of Bowlby's attachment theory in her "strange situation" research. In that research, they defined ambivalent infants as preoccupied with their mother's whereabouts, tense and unable to play in her absence, and who upon reunion exhibited anger or indifference. Their findings show that the reunion did not calm these infants, and they remained anxious and consistently preoccupied with the mother's accessibility. As I discuss below, Karen's manifest presentation and symptoms seem to fit the description of the ambivalent infant who later in life seeks out relationships of a symbiotic nature. The ambivalent attachment style is related to the fantasy of a harmonious regressive fusion with the mother designed to deny the possible separation. Later in life, the anxious child and adult's emotional investment is aimed at controlling and keeping the object alive, close, and inseparable. Karen talks about her fantasy of grandiose reunion and her need for reparation. The question she brings up time and again is: Who is responsible for the disruption?

In this chapter, I use attachment theory and infant research to focus on Pragmatic levels of communication and the ways in which contemporary psychoanalysis integrates these theories in clinical work. While exploring the Pragmatic levels, I will demonstrate how Pragmatic and Enigmatic communications are interweaving, and how every Pragmatic communication contains Enigmatic elements: unconscious and sometimes invisible.

When we talk about attachment, we always focus on disruption, rupture, and reparation. The therapist attempts to grasp the original disruption and the intersubjective failure, and tries to repair pieces of the original trauma through the therapeutic relationship. As we know, infant research and attachment theory emphasize the connection between relationships in infancy and adult treatment. Infant research findings support the centrality of the co-construction and mutual influence between parent and infant and between therapist and patient. Reviewing the literature and research, Beebe and Lachmann (Beebe, 2005; Beebe & Lachmann, 2002, 2003, 2013) note that infants are engaged in highly complex interpersonal interactions from the very first hours of their life. These interactions are mutual. An infant is not only influenced by the mother, but also influences and stirs her primal attachments. Karlen Lyons-Ruth (1999), the Boston Change Process Study Group (BCPSG) (1998), Lyons-Ruth and BCPSG (2001), and Daniel Stern et al. (1998) all present findings that support the understanding that primary dyadic relations are co-created. These findings back a notion of change that is not related to words or interpretation but to a shared implicit relationship between therapist and patient, to the

Pragmatic intersubjective meeting in a here-and-now occurrence and the emotional effect that the relationship itself brings about. Infant research yields results pointing to repetitive patterns of symbolic and pre-symbolic interactions that affect the representations of internal working models. Moreover, they suggest that the moment such a meeting takes place is also the beginning of a possibility for change. Based on the conception of the self as co-constructed through relational experience, the question I am dealing with is whether and in what manner repair is possible—or, as Karen asks, is she destined to go on killing those that she loves forever, without being able to revive them?

As the research shows, in the mother–baby dyad, the opportunity for reparation and reattunement following misattunement is more important than the avoidance of disruption. Therapeutic work is similar in that sense because it involves inevitable disruptions, painfully touches upon past disruptions, and offers new opportunities for repair within the therapeutic dyad. When working within the framework of attachment theory, the understanding is that all aspects of the therapeutic relationship are an important part of every therapy and reflect earlier attachment patterns, but that, in certain cases, the therapeutic relationship is not only part of the treatment but *is* the treatment. Wallin (2007) discusses separation and loss in the therapeutic relationship and the way separations evoke emotions that have to do with the patient's attachment history. When development is marred by trauma that is associated with separation and is left unprocessed, the patient responds forcefully to any hint of a loss of the therapist. Patients with a history of ambivalent attachment experience each temporary separation—sometimes even the end of a session—as an irreversible abandonment associated with the parent's wish to get rid of them. They respond especially strongly to the therapist's vacations, expressing or acting out their experienced sense of breakdown and fright (see more in Wallin, 2007). They cope with these separations as they did in infancy, whether through rage or expressions of helplessness, attempts to hold on to the therapist or to wean themselves from him, or by denying the separation through symbiosis. Each separation sets the stage for the trauma of a new loss that is to eventuate if this painful loss is treated the way similar ones were in childhood—unprocessed, denied, and unacknowledged. In such cases, the child's primal defenses and fantasies surrounding abandonment reemerge.

For patients like Karen, a young woman who started treatment only six months earlier, this language is unfamiliar and loss is still an unthought known (Bollas, 1987). Her parents are still alive, she has an older sister and a younger brother, "a healthy family," she says. At that point, the only way to recall her early emotional experiences is to experience them over and over again in adult life. And the question that arises is whether the treatment

becomes another in a series of proofs of the ineffectuality of hoping that someone will be able to take care of her the way she needs, to tolerate her aggression and need without abandoning her.

It is all over: the therapist had died

Karen arrived at the meeting with Dr. A enraged. She sat in the stairway and meditated before knocking on the door, telling herself "to behave." She entered and told Dr. A he looked well, and he replied that he looked better than he actually felt. In response, she addressed him directly and told him she was disappointed in him: "I feel abandoned. You're an abandoning therapist." The conversation became harsh. Karen was angry and directed accusations at him. She felt him getting angrier until he yelled at her, "I almost died. Do you hear me, you selfish thing? I'm human, too. Grow up. Stop it already, with all your feelings of deprivation and victimization." "It's not deprivation," she cried and retorted aggressively. "It's abandonment, do you hear? Abandonment! How dare you send someone else to inform me that you're sick. Who is he, anyway?" "That's none of your business," he answered. She told him that he was the one treating *her*, and not the other way around. She demanded to have him back. She wanted him to be responsible for her life, not only for his own. Dr. A tried to give her an interpretation about the way she repeats feelings of victimization and childlike demands. Karen told him he was a "shitty therapist," that his interpretations were worthless, that she saw exactly what was going on. At this point, the therapist asked her to leave the room. He said that as far as he was concerned, the treatment was over. She burst out crying and refused to leave. He offered her the names of other therapists. She replied by describing the sense that her body was betraying her and that she was losing control of it. She was about to throw up and began to hyperventilate. Still in his office, Karen conveyed the feeling that she was collapsing, her body shaking. She turned to Dr. A and asked, "What's happening to me? Save me." "Everything is going to be alright," he told her. Before she left, he asked that she call him the next day and leave a message to tell him how she was feeling.

Karen tells me these things while barely breathing. She cries and shouts, and I, fascinated by her story, feel as though she is pulling me into it with her. "No one can survive me," she tells me, and I understand that she is talking about the fact that I, too, will not be able to survive. She tells me that she phoned him the next day as requested and left him a message to call her back. She wanted to hear that he had survived, but, more than that, to verify whether the analytic couple had survived—to find out if he was still her analyst. She hoped with all her might that she had not killed him. She says that she wanted to hold him tightly, to erase everything that had happened, to stay together without his leaving her. She waited for a phone call from him, for reparation.

When he did call, she started crying. He told her that everything had happened for the better, that it was not that bad, that she should take a hot bubble bath and she would feel better. "At that moment I realized that it was all over, that the therapist had died, left me, that I had annihilated him," she says. He was no longer the therapist she had known. He gave her advice like someone off the street would, to try and artificially disperse the nasty odor. She should bathe and wash off everything that had happened, and so would he. She says repeatedly that she understood that he was weak. "The therapist died, he died. I killed him. I wanted him to hold me and say he would never leave me. I wanted to hug him, and he fell from the 20th story and crashed." She felt not only abandoned, but certain that when she used demands and aggression to retrieve him, she completely destroyed him, and he then left her forever. Karen touches upon the primal transgression she committed. "I'm a terrible person. I do terrible things," she says over and over again. "I wish someone would show me what it is that I did so that I would know how to stop it."

Vulnerability and destruction: a binary or complementary?

What had Karen done? How can we deepen our understanding of her feeling that she had done something terrible, her feeling that she is a horrible person who uncontrollably commits terrible acts, who murders? In order to reach such understanding, I shall present thoughts about the interweaving of internal and external worlds, confusion between abandonment and murder, as well as fantasies about weaning for the object. But first I would like to start with a view on aggression and destruction. As I listen to Karen, I think about her vulnerability and intense need, while I recognize the aggressive elements that she is struggling with and her fear of her destruction. The fears that we will destroy or be destroyed create deep anxieties, as fears of annihilation and disintegration are central human anxieties. In Karen's case, one level of that anxiety creates guilt based on the fear that she herself is destructive and might destroy the world she desperately needs. In fantasy, the lost object then was the child's responsibility and she destroyed it when she was needy and angry and continued demanding more and more from her mother. Such internal narratives include confusion between murder and parental abandonment. Fantasy and anxiety become fused, and, as always, in our clinical work the frame we create depends on the theory we use. Different approaches would suggest that we look at that confusion from different angles, and a clinical dilemma emerges. Should we, and in what ways can we, integrate the

patient's attachment trauma with an understanding of her destructive fantasy? In other words, can we empathize with the patient as a victim of parental aggression and intersubjective failure on the Pragmatic level (i.e., insecure attachment, trauma, etc.) and at the same time recognize her as victim of her own destructive fantasy?

When it comes to aggression, "good" and "bad" are the main characters on stage, and in clinical work we often encounter the problem of splitting between good and bad, aggressor and victim, internal and external, pre-Oedipal and Oedipal, and additional binaries. Fletcher (2013), following Laplanche, shows how in Freud's earlier trauma theory there was no split between trauma and fantasy. Rather, in the earlier theory, fantasy was a way of dealing with, representing, and defending against trauma. Freud creates the split binary between trauma and fantasy only later, when he abandons the seduction theory. According to Fletcher, Freud's original view can best be seen in the work on screen memory where *all* memory is a screen, hence there is no binary between internal and external reality, memory and fantasy, and displacement and condensation operate in all memory of reality. As I address throughout this book, the problem of splitting between external and internal, reality and fantasy, and Enigmatic and Pragmatic notions is crucial, and there is a clinical question as to whether or not we can break those binaries and work with the patient's fantasy, enigmatic material, and internal life while still holding in mind their early Pragmatic attachment, external experiences, and small "t" traumas.

Karen feels shaken and upset. She blames herself and at the same time feels victimized and innocent. I listened, and as I was aware of the impact of her words and of these words as creating an experience, enacting a scene, I knew Karen needed first to be regulated, to have a witness who is on "her side." After all, she chose an analyst overseas, who couldn't see her and that she couldn't see, which, as I discuss later, brings the topic of witnessing to the surface. But while framing the repetition of her early experiences of insecure attachment yields a good analytic narrative, and likely stirs the holding of the patient's early development and dyadic function, at the same time I wondered how much it leaves Karen to hold her aggression alone, as split-off parts that are kept outside of the analysis. I was curious to learn about and get in touch with Karen's destructive fantasies and did not want to assert the unconscious message that aggression is dangerous and that the one who is aggressive is bad while the victim, the innocent baby, is a good baby with no aggression or sexuality (see Atlas, in press). In that sense, we have to be aware that these splits might intensify the patient's entrenched dynamics and fear of their aggression, while denying their *and* our destructive forces, and ignoring the fact that a person afflicted with destructive fantasies is not only a potential aggressor, but also, and maybe mostly, a victim of her own disposition.

These splits between good and bad, victim and aggressor are so profound that we can easily find them in our theory as well as in our clinical work. For example, if we truly believe that we can be new, better objects for the patient than the original (bad) object was, we already split in at least two ways; we split the bad parent from the good baby (the patient), and the (all) bad original object (parent) from the (all) good new object (therapist). If classical theory is blamed for pathologizing the patient, the opposite extreme includes the perception of patients as innocent victims only, with no aggression or sexuality (see discussion in Atlas, in press). We see how empathy, tenderness, and even attachment often assume the absence of any "bad" parts of ourselves, and therefore we might leave parts of ourselves and our patients outside the room and project them onto and into other people (it's "they" who are bad). Working within a two-person psychology model, the main question is whether we can hold internal and external realities and not posit them as an oppositional binary. This would mean that when focusing on the actual Pragmatic interaction, we are able to hear the elements that are part of the unconscious communication, and recognize the intrapsychic reality that includes aggression, sexuality, and other fantasies that are shaping and being shaped by the external world.

Focusing on integration, Caper (2008) suggests we look at destruction through the lens of dependence and the reactions against that dependence on good objects. He believes that destruction in the form of envy or attack is the system's attempt to prevent breakdown related to the intense need of an uncontrollable object. It is the counterattack of whatever is threatening to break the system down. The destruction then is real in the same way that the threat to the mind is real. The unconscious wish to kill the parent, whom the child is unable to control, is not an expression of destructive instincts in the classical way, but rather an attempt to destroy or get rid of the dependency, while undermining the capacity to need or depend on a good object. Clinically, this presents a challenge for the therapist, who has to recognize the patient's destructive wishes and possibly actions while at the same time responding to the rage by identifying it as an attempt to self-cohere in the face of breakdown: a reaction to feeling that one's need is bad. At such moments, parental abandonment might be confused with murder. The primal inability to control the object produces in the child a great surge of rage and importunity. The child who experiences herself as angry and needy concludes that she is responsible for everything that has happened. She has great destructive powers that the mother did not survive, as evidenced by her desertion. The analyst can truly survive (as opposed to Dr. A's false survival) only if the patient's aggression and anxiety about the aggression are empathically acknowledged and processed—in other words, not being counterattacked or only defended against through empathic

Pragmatic narratives of the original misattunement. The needier the child, the more they experience themselves as destructive. Now any hug they wish to engage in will be infused with rage. The child senses that, instead of reviving the object, they kill it over and over again, to the point where they believe that they have totally annihilated the object. Neediness and love may be fused with rage and destruction and experienced as depleting and fatal.

Weaning from the object

Fairbairn (1940) discusses the early feeling that the object is empty and that it is the infant who has emptied it. The child who thinks that they lack love believes that their own love is "bad" and destructive. They are convinced that their coercive love will drain and destroy the object if they engage in sustained contact with it. They try to wean themselves from their need for the other. "I need to wean myself, as from drugs or alcohol. I must cut myself off because I love him too much, and this love is death for both of us," a patient told me, explaining that she had better kill her lover from within her psyche, otherwise her insatiable need would actually kill him, her, or both of them. This patient is defending herself from a loss she anticipates. She produces a fantasy in which she can control the loss and in so doing prevent the breakdown. Weaning is the separation attempt through which the child tries to rid himself of his neediness in order to protect himself and his mother from his need for her. Like Karen, these patients are involved with contradictory fantasies of both symbiotic fusion with the love object and weaning from it. Weaning is associated with addiction, dependence that has proven detrimental for both object and subject, and there is a fear that no matter what she does, she might still lose control and be abandoned. Weaning gives Karen the illusion of control.

Another patient told me in the very first session about his ambivalence toward white food: "I don't touch white food. I know it sounds childish, I just can't stand it, and I make an effort so that nothing white enters my body. It's a difficult struggle." We realize he refrains from drinking milk in order to forget its taste and not long for it—he wishes to wean himself from milk. He wonders how much milk the body needs and why people actually need it so much, or why someone would need me or anyone else, for that matter. He is ambivalent about the food I offer him, wishing to swallow but afraid that I will suddenly disappear and that he will not be able to go on without me.

Going back to a more classical point of view, Donnet and Green (1973) talk about "blank anxiety," a work that precedes Green's (1983) "dead mother." As opposed to red anxiety (castration anxiety) or black anxiety (associated with depression), blank anxiety is emptiness. Blank anxiety is

linked to the narcissistic injury of abandonment and loss. In our discussion, blankness has to do with decathexis of the mental primary object, which leaves traces in the unconscious in the form of psychic holes. The child continues dealing with the mother who abandons and threatens to abandon, with the question of who is responsible for her death, and with ongoing anxiety in the face of aggression, on the one hand, and dead and empty elements, on the other. Green stresses that it is not physical death we are referring to, but a mother who is present yet emotionally absent. Death is the loss of a live object that once served as a source of vitality for the child, and its transformation into a distant, present–absent object (Duparc, 1996). The child is preoccupied with retrieving the mother's full and present parts and at the same time is terrified of losing control and attacks the mother in different ways. What happens in moments when Karen experiences the therapist as abandoning? This is the moment when she uses all her might, becomes enraged, demands, and tries to control the object that is about to desert. An old and familiar fear of breakdown then emerges, and, as mentioned, these children do not experience relief even upon the mother's return because they are emotionally overwhelmed, vigilant, and fearful. Reunion, as Karen said, is always experienced as overwhelming and tragic.

Hope and reparation

I began contemplating the idea that Karen should try to meet with Dr. A and work through what had emerged for her. From a contemporary perspective, one of the things that most differentiates the present from the past and the analyst from the original caregiver is his willingness to acknowledge what was heretofore denied. In this case that would mean that Dr. A would need to take responsibility for his own difficulty in tolerating Karen's response to his illness. I hoped that the experience of retraumatization could be recognized and explored, and thus transformed into a reparative experience that could heal the rupture of attachment, but I realized that if I suggested she meet with him, she might experience me as wishing to get rid of her as well. I share my dilemma with Karen, telling her that I am concerned that she will feel not only that I am afraid for my life—a passive, helpless, impotent witness to the one who hurt her—but also that I am sending her back into his dangerous grip. We discuss the pros and cons of such a meeting. Karen subsequently presents a dream in which she comes to Dr. A's office and he opens a different door to his room than she is familiar with, telling her, "Don't worry, I've begun smoking again." She says that she felt relief at that moment, as he once again became who he had always been. The therapist is reconnected to the cigarette, to her; he holds her, he is her live therapist. Karen decides to meet him again.

Karen returns from that meeting sad and quiet. "I wanted him to tell me, 'Karen, we experienced something crazy here'—with an emphasis on '*we* experienced.' But he said, 'You experienced. I have nothing to do with it. You bring your psychology to the room, and I was there to show you how you act.'" "Where are you?" she asked. "Who are you in this drama, why am I alone here?" To Karen, the therapist who insisted on remaining the one who reflects solely on her psychology is a liar and a coward. She feels that she saw him vulnerable and shameful. She experienced horror in his voice and words, and she interpreted it as a fear that she would annihilate him. This touches upon her own experience of herself as an annihilator. She blames him, and he blames her. They were caught in a doer and done-to cycle, trapped in the ping-pong of blame (Benjamin, 2004b). They both feel blamed rather than responsible, controlled rather than recognized. Benjamin writes that, in those situations, the analyst's acknowledgment of her part in co-creating the mutual dynamic, especially when it feels hurtful, allows the "third" into the room. Karen needed affirmation of the fact that what happens in the room belongs to the therapeutic couple and not to her alone. As long as the therapist does not acknowledge this, he leaves her alone, abandoned, guilty, and destructive, and he remains a false, horrified, and absent figure. We realize that this is the primary object she knows so well. His choice to not talk about what happened to *them*, as a couple, or to acknowledge his contribution intensifies the horror and perpetuates the experience of an absent parent who is preoccupied and fighting for his life at the expense of his child. Karen feels abandoned and betrayed. Again, she has not found a secure base, leading her to question the very possibility of hope in relationships.

Words

Karen presents a dream. In her dream she is 16, standing by a high railing, when she suddenly falls down and crashes. From above she looks at the girl who has just crashed and sees all of the people gathering around her: her parents, her siblings. Everyone is looking at her, but they do not see what has happened to her. It is only she who is above, looking, seeing, and understanding what has happened. No one else understands that she has crashed, has been destroyed. We talk about the 16-year-old girl who appears in the dream, and she tells me that the most painful separation of her life occurred at that age. She had separated from her first boyfriend, her first love. "Maybe I never overcame it," she says. This is the moment when she introduces the girl that she once was, the pain of separation from the first love reverberating with the pain of earlier, more primary breakdown, a trace of crashes that no one had seen, no one had served as witness to (see Felman & Laub, 1992; Poland, 2000; Ullman, 2006).

Karen and I talk about her need for me to be a witness who testifies on her behalf, who affirms her sanity and, especially, her innocence, helping her to be able to tolerate her aggression and not be afraid of her destructive actions. I am overseas, a witness who cannot see or be seen, a witness who can only hear her words. Karen says, "You cannot die, since you are only partly alive." I believe the phone sessions create an environment where we are both "safe," but also only partly exist. She is not as worried about her destructive power when I am far away, and at the same time I know—and later on she does, too—that I am serving as a bridge between the past and the future, until she is able to connect to a "real live" therapist. Karen constantly needs recognition of her subjectivity. "Do you understand that? Do you know what I mean?" she asks over and over again. But at the same time she is worried the witness might be destroyed, too. She experiences herself as toxic, she is afraid she might be contaminating (Gerson, 2009). And so my being far away, listening but not physically present, is a relief. My role is to *listen* to the story, as I listen to the way I listen (Faimberg, 1996). We question my role as a witness, speaking of the witness as someone who enables the story's hero to exist, because without this hero the protagonist has no life; there is only a void. She never had a reliable witness, and in external reality, as in her dream, there is almost no trace of what Karen has experienced, and there is no one who can testify from the outside and validate her subjective experience.

Karen's words are a way to work through that gap between experience and the outside world. They tried to negotiate the space between two people, the slit that is necessary for a language to emerge. Amir (2013) writes that language is first and foremost a depressive achievement, the giving up of the symbiosis with the other by acknowledging him or her as a distinct subject. "The transition from a mouth filled with the breast to a mouth filled with words occurs by virtue of the intervening experience of the empty mouth" (Torok & Abraham, 1994, p. 127). The empty mouth, which is the separateness from the mother, is the beginning of a different full mouth, with language. It is when the other isn't inside of me and I am not inside of her, we are not part of each other, that I have to tell her how I feel (Amir, 2013; Roth, 2013).

For Karen, separateness is too painful, and she asks for a symbiotic surrender. She demands to be inside the other, to know that she is never alone, that the other belongs to her, and she achieves this through verbal intensity. I feel her powerful push for symbiosis and at moments am threatened by her need to aggressively and forcefully engulf me, which is embodied in the flow of her speech. Joseph (1975) suggests that most of what a patient communicates in a session is expressed through the use of words as carrying out actions, to *do* something to the analyst or to make the analyst do something. In this case, the words are not only what they say but

what they actually do, and an enactment unfolds. Fusion becomes the defense not only against abandonment, but also against any negative feeling, hostility, hate, and envy. The recognition of the separateness of self and object is the loss of the good qualities of the other that otherwise belong to me. It's hard to formulate concepts of hate and envy when there is fusion, when self and object are one.

One needs language and words to "know," writes Ogden (2004), and, I add, to know that they know, which is a more Pragmatic piece of knowing, if we assume there are many ways we know Enigmatic Knowing. Language thus becomes a signifier for a feeling (see also Bion, 1977). When we listen to words, we have to also listen to the silent noise of what occurs in those white spaces between the lines, in the breaks, staccatos (Knoblauch, 2000, 2011, 2012). Bion (1977) talks about the gap, the caesura, and the ability to listen beyond the "noise" of the speaking words. He explains how words help us avoid the Truth, fill the emptiness, and avoid contact with real pain and the actual storm that the contact with material might evoke. The Enigmatic lives in that gap. The process of one mind listening to what another mind is unable to hear, or as Bion (following Boris, 1986) defines it, implementing what another mind is not capable of, is based on our ability to not listen to the actual, to the "grownup conversation that is happening in the room." That listening is the letting go of what words signify and the familiarity of mature and verbal thinking[1] (Bion, 1977).

Karen fills the emptiness that would otherwise allow for my separateness, for me being outside of her control, with words. We later understand that the difficult interaction with Dr. A is similar in that sense to the interaction with me and to Karen's other interactions, which are, in large part, a defensive strategy. Ogden (1994b) writes that words can function to avoid collapsing into despair: "Trying to keep a beach ball in the air" (p. 174), so it won't fall, and so we won't fall with it into the void, into pain, despair, or deadness. Amir (2013) defines the "pseudo-language" where "the psychic discourse remains barren and empty, high brow, and false" (p. 3). Certain kinds of verbal intensity are then what Amir calls the rejection of the "melancholy of language." They are the defense against the separateness from the other and are based on omnipotence, which is a refusal of separation and the mourning of that separation. The types of turbulent interactions with the other are meant to continually drive the other to respond at the level that one needs, so they are both intensely engaged with each other, but also limited in their ability to think and fully feel. It is a way to control the analyst's mind so it won't threaten the patient with independent thinking, but still remain alive and active. This complex demand will potentially allow Karen to make sure the other does not remain passive or die on her, but at the same time control his dangerous independent mind. It is interesting to think about the false level of aliveness

in both analyst and patient and the deadness underneath; the analyst will be engaged but his mind will be controlled, and she will be emotionally alive, filled with feelings and words, but intensely defending against real knowing.

Creating and separating

After about a year, Karen informs me that she found out Dr. A died from AIDS. She is heartbroken. She tells me that now knowing Dr. A must indeed have been overwhelmed with his own health and feared for his life makes her even more sad, as she feels that she should have been more careful, more sensitive; she should have taken care of him instead of attacking him. What we would do if we were Dr. A is of course a topic for another discussion, as we therapists struggle with life events and traumas (see Kuchuck, 2014), and the questions of inadvertent and deliberate self-disclosures and the numerous ways in which we bring ourselves into the analytic room are always there.

Soon after we hear about Dr. A's death, I visit Israel and meet with Karen in person for the first time. That meeting was the beginning of our separation, as we felt and addressed the limitations of the phone sessions. We discussed the possibility of my referring her to someone else, someone that she can meet and know fully. During that meeting, while I sit in front of her, Karen starts writing her story, and we end up sitting and writing it together. She gives it to me as a separation gift, asking if I will hold her story with me and keep it for her while she moves on with her life—to her first session with her new female therapist, to meeting her husband, and to giving birth to her first and then second child. She asks me one thing: that when discussing her story I will not separate from her in the reader's favor. We acknowledge her pain about the fantasy that while using my mind I might stop thinking of her and get new ideas or enter someone else's mind. The invasion of thought—my own and the reader's—endangers the dyad and the illusion of control.

Part of my choice to write the story with Karen also has to do with the understanding that in order to create an experience in which there is a third, she must be part of the trio rather than excluded. I do not perceive my choice as only serving to assuage her anxiety—I also see it as recognition of her yearning for development and growth. Even while assuming that the therapeutic bond is meant to create a different model of attachment—one that is more secure and reliable, one in which the therapist and the patient can acknowledge childhood traumas and work them through—as mentioned, I am aware that the attempt to become a "better" attachment figure can be a setup for splits between past and present, good and bad, victim and perpetrator, and repetition of the attachment failure will always take place

at some level. In this chapter my aim was to rethink these binaries and open a way to think about integration of phantasy and internal world with external reality, trauma, and Pragmatic elements.

Note

1 This is related to Bion's ideas on reverie and dreaming.

Chapter 8

Galit

Sex, lies, and psychoanalysis

War

It was a week before my 18th birthday when I left my parents' home. I recall packing my clothes in a suitcase, my mother standing silently in the corner and my father locked in his room. I fled.

He was 24 years old. I thought he was a grown man and that I was running away to the safest place on earth. I didn't think he was the love of my life, but he offered me a home, and I followed him.

I was scared, and soon enough I realized I wanted to go home. It was the first—but not last—moment in which I understood that I didn't know where my home was. I sat on a bench under his apartment on King George Street in Tel Aviv. If I had known how to smoke then, I probably would have, and I thought that maybe I should have sex with him after all, maybe it will change everything. I went back up and told him that if we get married, I'll have sex with him. He looked at me and said one sentence: "I don't get your sexuality." Shrugging, I said, "Neither do I."

The next day he bought me a ring and offered to marry me. I remember packing my clothes again. I had told myself that I had chosen a grown man so that he would understand everything that I don't, so that he would offer me answers. But he had no answers, and I left him a note—"Sorry, I'm going to look for answers"—and left.

Fortunately, my inner struggle found expression in the external world, in that very same month the Gulf War broke out, and missiles hit Tel Aviv. I was then a soldier in the Israeli army. On the first night, closed in a sealed room with gas masks on our faces, we heard the missiles fall and we realized we were all going to die. On the second night an undulating siren was sounded, and we thought that maybe the warheads weren't chemical after all. There was great commotion. Home was no longer something defined; everyone slept everywhere. One did not need a home to survive, only a mask and a public shelter. My father was drafted into the army, and, like most of my friends' parents, my mother took my young siblings and